“What constitutes a good enough life for someone with lived experience of homelessness and drug or alcohol addiction?”

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"Tell the story of the mountain you climbed. Your words could become a page in someone else's survival guide." — Morgan Harper Nichols

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Types of homelessness are wide-ranging and can include street homelessness, staying in temporary accommodation like shelters or hostels, and unsuitable accommodation like squats, tents or other temporary dwellings (Bramley, 2017). A vast amount of time, money and resource has been allocated to determine the causes of homelessness, but the problem persists. A recent count of rough sleepers in the United Kingdom shows a rise of 134% over the preceding six years (National Audit Office, 2017). For the homeless individual, the realities of being unhoused are in stark contrast to the average housed individual: increased risk of long-term physical health problems (Homeless Link, 2014), cognitive and neurological impairments (Backer & Howard, 2007), and mental health difficulties (Rees, 2009). Homeless individuals are also at great risk of physical and sexual assault (Breakey & Fisher, 1990) and more likely to develop suicidal thoughts and behaviours over time than the general population (Eynan et al., 2002).

There are systemic consequences of homelessness, including an increased spend by health services; an estimated £85 million per year (Department of Health, 2010). Despite various strategies to both prevent and intervene, homelessness remains a significant problem for health and social care agencies and a challenging moral dilemma for society. Although there is a significant body of research examining the antecedents of homelessness, the multi-dimensional and systemic factors that can lead to a person becoming homeless are often denied or minimised. This can create a situation where society perpetuates the problem of exclusion that it seeks to alleviate (Jordan, 1996; Wilkinson & Pickett, 2009; Cooper & White, 2017). This can lead to demoralisation and disappointment among front line support staff working in

services (Adlam, Kluttig, & Lee, 2018). Responses to lack of success in services reaching out can vary but can lead to the individual retreating further from reach (Armstrong, 2018) and services becoming increasingly difficult to access (Fitzpatrick & Pleace, 2012).

The systematic literature review (Chapter One) sought to explore the contribution of the *Capability Approach* to the provision of mental health services. The Capability Approach is a human development framework which has contributed to the advancement of social justice and a recognition of the interaction of micro, meso and macro factors on an individual's health and wellbeing around the world (Nussbaum, 2011). The application of the approach to mental health is more recent, and to date, there has not been a comprehensive exploration of how this approach has been applied to mental health services.

The research paper (Chapter Two) addressed the experiences that formerly homeless individuals had in seeking help and support, and also asked professionals working in homeless services what it was like to provide services to homeless people. The systemic barriers and individual challenges were discussed. A qualitative methodology was used to capture the experiences of both groups of participants, using 1:1 interviews for individuals with lived experience, and focus groups with professionals.

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Chapter One

Systematic Literature Review

"What has the *Capability Approach* contributed to Public Mental Health Services?"

Word Count: 8535

Abstract

Background

This review sought to identify and synthesise emerging research on the use of the Capability Approach (CA) within mental healthcare.

Methods

Five databases (PsychINFO, ProQuest, CINHAL, SCOPUS and Web of Science) were systematically searched. Ten papers met inclusion criteria to the review and were analysed using a meta-ethnography approach.

Results

The synthesis of themes and concepts from included papers resulted in four key concepts and a line of argument synthesis. Key concepts were: Activating Choice, Connection as Healing, Mobilising Empowerment and Systemic Barriers to a 'good life'.

Discussion

The Capability Approach offers insights into the provision and structure of Public Mental Health (PMH) services, including the need for informed choice for service users and advocacy to support the development of adaptive capability. Further work in this area would be valuable to determine how the Capability Approach could meaningfully be applied to PMH services.

Introduction

The Capability Approach (abbreviated to 'CA' hereafter) names systemic sources of oppression and injustice (sources of unfreedom) and the resulting impact on the individual's ability to achieve their own 'subjective wellbeing' (Nussbaum, 2011). The approach emphasises that the meaning ascribed to the determinants of wellbeing is as important as wellbeing itself and highlights the subjective nature of these determinants. So, while two individuals may have a separate definition of what constitutes wellbeing, the emphasis is on the personal values that underpin their respective sense of wellbeing. Thus, the CA suggests that these values can be supported through a comprehensive framework that enables individuals and communities to flourish.

Public Mental Health (abbreviated to PMH hereafter) refers to the science and practice of promoting mental health at a policy level, with the aim of reducing mental ill-health and distress (Eaton & Fallin 2019). PMH has grown as an area of interest for study as more attention has been focussed on equity and equality of mental health services across the world. Aside from the direct health consequences and increased risk of premature mortality for people experiencing mental health problems (Whitmee et al., 2015), there is also the impact on social and psychological functioning and the increased prevalence of downward social mobility. This is particularly evident among vulnerable and minority groups due to institutionalised oppression and inequalities in how diagnostic and treatment services are provided (World Health Organization, 2010). This 'treatment gap' is theorised to contribute to

the increase in time spent living with ill health across the life span, and poorer outcomes for individuals experiencing difficulties with their mental health (Andrews & Titov, 2007). Despite the concerns raised in reports by the Lancet, World Health Organisation, American & British Psychological Societies and others, funding for PMH programmes remains poor, with most countries investing less than 1% of health budgets in mental health (Mind, 2016). This lack of investment in PMH within social policy, health budgets, front line healthcare and community support services has led to mental health being described as the most neglected human health condition and a “moral failure” (Kleinman, 2009, p. 604).

PMH has been a particular focus in the United Kingdom since 2008, when the Foresight report was published on the topic of ‘mental capital’ and ‘wellbeing’ (Capital, 2016), which provided impetus at a policy level to improve average wellbeing across the population with the assumption that this would decrease the number of people diagnosed with a so-called ‘mental disorder’. However, this wellbeing approach, which was then embedded within mental health policy in the UK, has been problematic. There is significant difficulty in accurately defining or measuring ‘wellbeing’ and using standardised psychometrics to measure mental ill-health and wellness, assuming that these exist on the same linear spectrum (Robertson, Leach, & Dawson, 2018).

The difficulty in constructing a meaningful conceptual framework for PMH services is partly due to the blurred definition over what constitutes ‘wellbeing’ for individuals using those services (Forgeard, Jayawickreme, Kern, & Seligman, 2011). An

individual's 'wellbeing' may be defined very differently from the perspective of a service commissioner or government policymaker, compared to how a person may define it personally. This is not a new dilemma. Many academics, philosophers and theorists have attempted to define what it means to have personal 'wellbeing' and this has created contradictions within the evidence base, with definitions and concepts defined differently depending on the theoretical perspective of the researcher (Pollard & Lee, 2003). Historically, this concept has been approached from two distinct branches of understanding; the hedonic - focused on happiness, positive affect and satisfaction with life (e.g.: Bradburn, 1969; Kahneman, Diener, & Schwarz, 1999) and the eudemonic – which emphasised positive psychological functioning and human development (e.g.: Rogers, 1961; Rhyff 1989).

While a concrete, quantifiable definition of 'wellbeing' remains elusive, there is now a consensus that it represents a more dynamic and multi-dimensional construct that early theories failed to account for (Diener, 2009). Bradburn's (1969) research on 'happiness' looked at how people respond emotionally to challenges in their everyday lives, as opposed to examining individuals through a purely psychiatric lens. His work maps on to Aristotle's concept of 'Eudaimonia' – translated as 'wellbeing' – and stated that psychological wellbeing "stands out as being of primary importance" (p. 6).

Further work into the understanding of happiness and wellbeing has been criticised for failing to provide a coherent definition of wellbeing and continuing to offer only descriptions of the concept (Christopher, 1999). Joseph and Wood (2010) have called on clinical psychology to adopt measures of positive functioning as a contrast to

what they describe as a reductionist view of wellbeing when measured purely as “an absence of distress or dysfunction” (p. 831). The use of standardised measures to gauge the severity of various mental ‘disorders’ and reliance on diagnostic criteria and labels to measure wellness, illness and recovery means that, at the policy level, the focus on individual ‘recovery’ not only locates the origin of mental distress within the individual, but also minimises the various factors that can influence mental health and wellbeing, such as the iatrogenic effects of psychiatric treatment (Newcomer & Hennekens, 2007) and systemic factors, such as poverty and social deprivation (Colton & Mandersheid, 2006).

More recent ‘health promotion’ campaigns have further emphasised the origin of wellbeing as purely within the individual with many preventative programmes focused on obesity, ‘healthy eating’ and ‘being active’ (Lupton, 1999). These programmes effectively ignore the economic, cultural and political conditions that people live in and further reinforce the notion of ‘personal responsibility’ as part of neoliberal discourse on health and wellness (Labonte & Stuckler, 2016). Given the current levels of inequality in the world, where “62 people hold as much wealth and resources as the rest of the world’s 7.4 billion residents” (Oxfam, 2016) it seems remiss to ignore inequality as a source of psychological and emotional distress when thinking of economic and political determinants of health. Disparate levels of equality impact health and health services both at a micro and macro level; the dissonance between widespread levels of inequality and government directives to cut spending on welfare and support services seems to be reflected in the ‘treatment gap’ between what people need and what services are on offer (Bauman, 2013).

Historical approaches to defining 'happiness' and 'wellbeing' have focused on dimensions or descriptions rather than meaningful definitions (Forgeard et al., 2011). Theories that were thought to define each of the terms above have since been demoted to facets of a nebulous, difficult to quantify concept. Many attempts have been made to pin a definition down for the purpose of optimising and coordinating human behaviours (Layard, 2005). Duckworth, Steen and Seligman, (2005) describe the field of positive psychology as grounded in the belief that human strength and virtue can buffer against mental illness and seeks to broaden the scope of clinical psychology toward prevention of mental distress by fostering positive emotions. Within the field, personal happiness has been the focus of organisational and therapeutic efforts (Gable & Haidt, 2005). It has shown to be effective at increasing individuals' ratings of happiness after six months (Seligman, Steen, Park, & Peterson, 2005) and there is evidence the approach works well with older adults in particular (Ranzijn, 2002). The work of positive psychology and its influence on popular culture has not been without criticism, with some characterising the movement as an advancement of a 'capitalist bureaucracy', keen to produce 'happy robots' and increase consumption, rather than true fulfilment and happiness (Wong & Roy, 2018).

The CA emphasises the importance of personal agency and freedom to carry out the important activities one has reason to choose (Sen, 2000). These freedoms are often limited by structural barriers to people with mental health problems and for individuals whose lives and experiences are bound by poverty, loss, trauma or social

exclusion. Public agencies and services can collude with exclusion by denying freedom to individuals and limiting their agency by designing services with a paternalistic, top-down assumption of what people need and what they are capable of (Sikkema et al., 2007).

It has been suggested that traditional approaches to social policy fail to understand what people actually 'do and choose to do' in the contexts and environments in which they find themselves (Clarke, 2004). The idea of 'subjective wellbeing' is the opposite to traditional top-down, reductionist, economic evaluations of welfare and instead emphasises what the individual is able to do with the resources available – termed 'functionings and capabilities'. Nussbaum (2011) argues that the CA is a necessary counter to traditional utilitarian and neoliberal social policies, which can reinforce injustice and inequality by ignoring aspects of quality of life which do not correlate with economic growth, or by conflating "wellness" with economic productivity.

Rationale for the Review

To date, research in the area of capabilities and PMH has been limited and consequently, there has been little work done to systematically identify and synthesise what has been done to advance knowledge and understanding in this area of research. The CA focuses on the empowerment of the individual by promoting agency, but also a recognition of the material resources that are required to lead fulfilled lives, bridging "material and social registers of disadvantage" (Hopper, 2007). This complements movements within community psychology, which focus on transformative and ameliorative change in systems, by challenging oppression and unequal differences in power (Nelson, Prilleltensky, & MacGillivary, 2001). This review has implications for people with lived experience of mental health difficulties and mental health professionals. Knowing that people who experience mental health difficulties can experience stigma and prejudice, and that structural inequality and oppression can lead to a range of psychological difficulties, it seems important that clinical psychology should examine 'exits' for a system which supports people in need of care. It is also worth noting that the experience of long-term mental health difficulties has been implicated in a higher risk of developing a variety of physical health conditions (Newcomer & Hennekens, 2007).

The CA has been widely debated in the fields of economics and philosophy, and to a lesser extent within health (e.g.: Venkatapuram, Bell, & Marmot 2011; Ruger, 2012),

gender discrimination, poverty and disability (Welch, 2002) but the application of CA to the area of mental health and mental health policy has not yet been widely considered.

Systematic reviews in health research have traditionally focused on measurable, quantifiable variables (Gough, Thomas, & Oliver, 2012). More recently, systematic reviews of qualitative and mixed-methods studies have become increasingly common, due to growing recognition of the need for different forms of evidence in explaining complex social phenomena (Dixon-Woods, Fitzpatrick, & Roberts, 2001). Reviews of quantitative studies typically address questions about what works, while reviews of qualitative evidence tend to address questions about what matters to relevant stakeholders (Petticrew & Roberts, 2006), and can be thought of as 'reviews of views' (Stansfield, Brunton, & Rees, 2014).

Aims

The primary objective of this review was to systematically review relevant literature around the CA and mental health services and to synthesize this information using a meta-ethnography analysis to answer the questions: 1) "from relevant literature, how has the capabilities approach been used within mental health services to date?" and 2) "how has the Capabilities Approach contributed to the understanding of how those mental health services are provided?"

A secondary aim of the review is to provide a basis for future research and identify opportunities for expansion of the use of the CA within a PMH context.

Method

The review had three stages: a systematic search of the literature, critical appraisal and synthesis using techniques of meta-ethnography originally proposed by Noblit & Hare (1988).

Systematic Search

To identify the scope of the review, search terms were guided using a PICo Framework (Cherry, Perkins, Dickson, & Roland, 2014). PICo is used as an abbreviation of 'Population' (in this case referring to mental health services), the area of interest (The CA) and the context (in this case, how PMH initiatives are understood through the lens of the CA). Scoping searches were used to refine search terms. The final guiding definition for the meta-ethnography was the synthesis of published, qualitative, or mixed-method papers, that speak to the application of the CA to conceptualise an area of mental health service provision.

Search Strategy

A systematic search of five databases: PsychINFO, Web of Science, ProQuest, SCOPUS and CINAHL was conducted up to March 2019.

The search strategy was adjusted for each search using the Kings College London library guide. Each search contained two clusters of search terms; 1) the CA and 2) Mental health difficulties & mental health services. Search terms used in cluster one

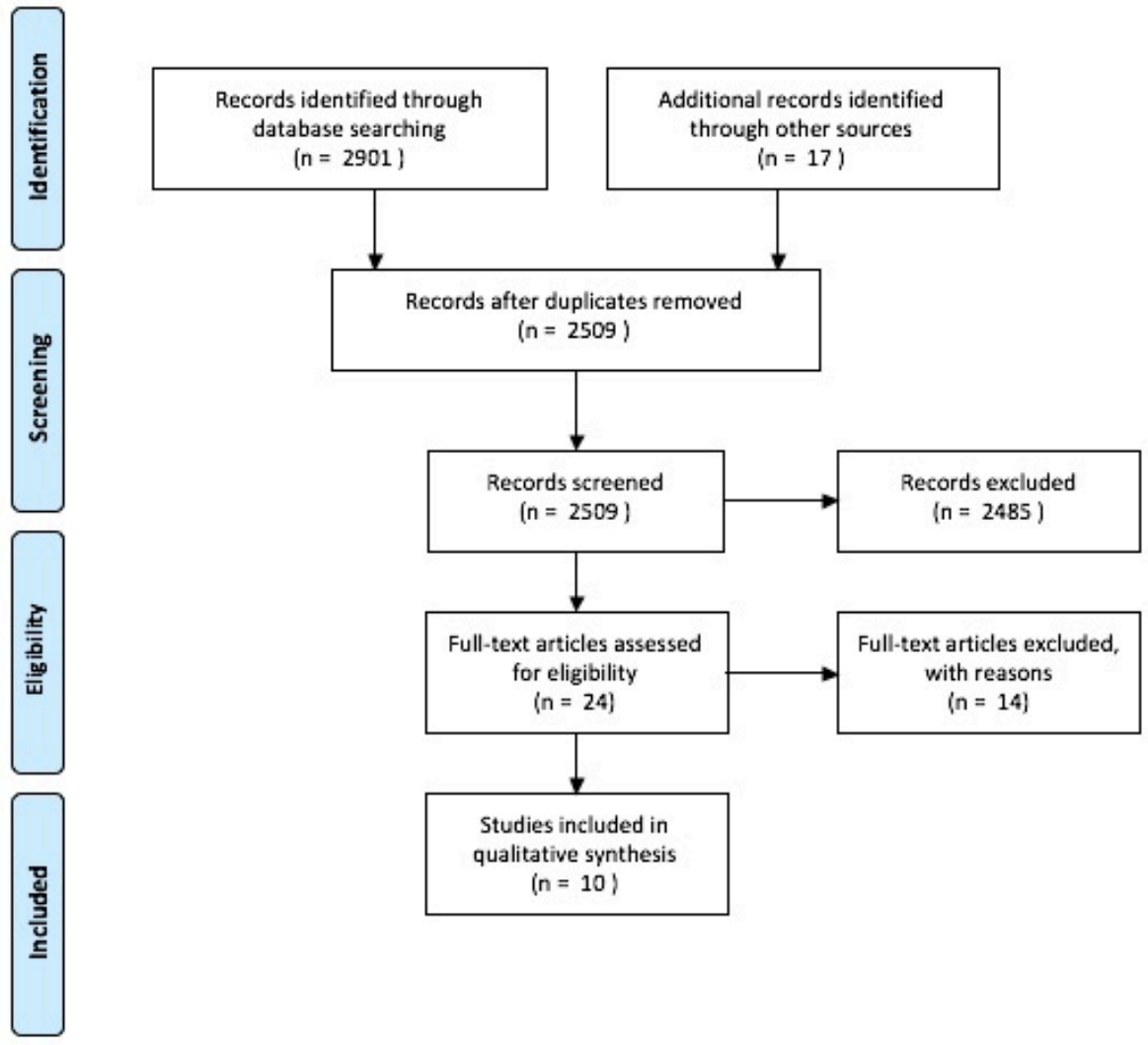
were: “Capability approach”, “Human development approach”, “agency”, freedom”, “functionings”. In cluster two, the search terms were “mental health”, “mental distress”, “wellbeing”, “mental illness” “mental health services”. Where possible, the thesaurus function was used in each database to provide breadth to the search. The two clusters were combined used the Boolean logic terms “or” and “and”. There was no time limit placed on the searches. Reference chaining was also used. Relevant authors and working groups were contacted to determine if they knew of any further work relevant to the review. Three papers were identified using reference chaining. Contacting authors and working groups did not generate any new articles for inclusion that were not already present from the database searches. Search terms can be found in Appendix N.

Inclusion and exclusion criteria

Criteria for inclusion at this stage of the review were: 1) the paper was published in English, 2) the paper was a peer-reviewed journal article, which collected primary data, and 3) the method used in the article was qualitative or mixed methods. Duplications were removed at this stage. Screening questions for inclusion were: “Does this paper specifically mention the CA in relation to mental health?” and “is this paper relevant to the scope of the meta-ethnography?”. One reviewer (BC) screened all titles and abstracts. A colleague (SJG) screened a subset. Papers were removed for a variety of reasons, including quantitative research, no mention of the CA, commentaries, theoretical pieces, or they were not relevant to the review interest, see Fig 1. The database searches produced 2190 results. After duplicates and papers

not suitable for the review were removed, 24 papers were included in a full-text review, of which 14 were excluded, with reasons, see Table X (Appendix O).

Figure 1 – PRISMA Flow Diagram



Final Papers for Review

Ten papers met the inclusion criteria and screening for inclusion in the synthesis. In total, papers included 688 participants from countries around the world including Canada, the United Kingdom, South Africa, the United States, Israel and Portugal. Papers were published between 2007 and 2018. Each paper for inclusion was evaluated using a methodology reported by Dixon Woods, (2006), where papers that were deemed relevant and conceptually rich were evaluated as being a “key paper” (KP), a satisfactory paper (SAT), Unsure (?), irrelevant to the synthesis (IRR) or flawed (FF). A variety of Qualitative methodologies were used, included thematic analysis, grounded theory, interpretive phenomenological analysis and ethnographic enquiry. A full list of included papers and their distinctive features is found in Table

	Table 1: Characteristics of included studies (n=10)					Key: 'KP' = Key Paper, 'SAT' = Satisfactory Paper	
	Study Citation	**Country**	**Sample Size**	**Context of Study**	**Method of Analysis**	**Study Aims**	**Key Paper?**
1	Ware, 2007	USA	56	Adult Community Services	Interpretive Approach	Address persistent social exclusion for psychiatric patients, using a new definition of social integration, informed by the CA.	SAT
2	Lewis, 2012	USA	74	Community Mental Health Centre	Ethnographic Enquiry	How capacities for social integration of people with mental health difficulties can be strengthened and promote recovery. Informed by the CA.	KP
3	Mall, 2013	South Africa	17	Antenatal Service	Framework Analysis	To develop interventions for Antenatal MH distress informed by the CA.	KP
4	Benbow, 2014	Canada	380	Adult Community Services	Mixed Methods, Thematic Coding	To better understand the experience of poverty and social exclusion of psychiatric survivors using the CA to social justice.	KP

5	Sachetto, 2018	Portugal	65	Community Mental Health Services	Thematic Analysis	Collaborative development of a CA based tool for consumers of community mental health services.	SAT
6	Meintjes, 2015	South Africa	5	Perinatal Mental Health	Content Analysis	Using the CA to explore the deprivational impact on maternal mental health.	SAT
7	Petros, 2016	USA	6	Adult Community Services	Narrative Analysis	To evaluate how participants made meaning from systemic barriers to recovery. Informed by the CA.	KP
8	Light, 2016	Australia	38	Outpatient Psychiatric Unit	Grounded Theory	Build a model of capacity for people who are receiving involuntary outpatient psychiatric care. Developed using the CA.	SAT
9	Brunner, 2017	United Kingdom	22	Adult Community Services	IPA	Operationalising the CA with people who have recent experience of inpatient psychiatric care, to conceptualise what may cause poor social outcomes for this group.	KP
10	Lavie-Ajayi, 2018	Israel	25	GP Clinics, Community	Thematic analysis	Understand barriers to healthcare for people with severe mental illness, using the CA.	KP

Critical appraisal

The difficulty of navigating tension between reporting quality and relevance to the aims of a review has been noted by other researchers (e.g.: Dixon Woods, 2001), and others have suggested that quality appraisal is a 'matter of taste' (Sandelowski, 2015) and some authors suggest that whether or how to apply quality appraisal to qualitative papers imposes a positivist approach to 'quality' on studies which might be from different traditions (Barbour, 2001). To assess the quality of the papers included for synthesis, the CASP (Critical Appraisal Skills Programme) checklist was used (Public Health Resource Unit, 1998). The CASP seeks to provide a robust measure of the common features of qualitative research, namely: credibility, rigour and relevance, measured using ten items. For the purpose of this review, papers were not excluded based on the CASP assessment, as they might have still been relevant to the synthesis and to avoid limiting the potential for insight to be found.

The appraisal process was used to get a sense of the quality and content of the papers included for the synthesis. CASP assessment outcomes are shown in Appendix P. Two colleagues, CMcG and SJG appraised a subset of the papers using the CASP criteria. There was some variation in how studies reported their methods and findings. The rationale for all studies was clearly reported and despite the differences in how the CA was applied between papers, the relevance to the approach was clear, regardless of methodology used.

Data Synthesis

There are a number of ways to synthesise qualitative literature and research (Dixon-Woods et al., 2007). In this review, a meta-ethnography approach has been used, as developed by Noblit and Hare (1998), and adapted for research e.g.: by Britten et al., (2002). Meta-ethnography shares some of the same goals of meta-analysis, but its purpose is not purely to aggregate the findings of research articles. Instead, it is used to develop conceptual insights and interpretations by "translating" studies into one another to develop a "line of argument" synthesis.

Reading the studies

The first step in the meta-ethnography approach involved the reading and rereading of the chosen papers to identify the findings and main concepts. Study characteristics including sample size, country, the context of the sample and use of capability was recorded in a table (See Table 1).

Determining how the studies are related

This stage of the analysis required identifying recurring concepts from each individual study. Instead of constructing themes from studies, in a meta-ethnography, the aim is to construct "third order interpretations" from the second order constructs within the selected studies (Britten et al., 2002). The definition of what constitutes a

first, second or third order construct can vary in the synthesis literature, so a definition was taken from Britten et al., (2002), shown in Table 2.

Table 2: Working definition of first, second and third order constructs (Noblit & Hare, Britten et al, 2002)

First Order Constructs	Second Order Constructs	Third Order Constructs
Participants' quotes relating to mental health & applied to CA in the paper.	Authors' interpretations of participants' experiences through the CA framework.	Views of this paper's author, expressed in themes and key concepts.

Table 1 was used to record the characteristics of each study. Table 3 was constructed to note down key metaphors, key words, ideas and concepts, then, second order constructs from each paper were incorporated, illustrated by raw data from the papers themselves, as well as keywords or concepts which fed into the development of third order constructs. Extracted data was useful at this stage to "preserve the structure of relationships between context" as described by Britten et al., (2002, p.209) as the meta-ethnographic approach emphasizes the contextual preservation of meaning.

Translating studies into one another

With the details, context, concepts and themes of each paper in a table, this stage involved comparing concepts and themes of each paper between and against one another – "translating the interpretations of one study into the interpretations of another" – (Noblit & Hare, 1988, p.25). First and second order constructs were compared and contrasted. The development of third-order constructs was reviewed and reflected on with a second reviewer, CMcG. Third-order constructs in the form of key concepts and themes are found in Table 3. First and second order constructs were included as evidence for key concepts as a way to stay close to the data and as a way to effectively summarise the findings from each paper, using salient excerpts from the data.

Results

Synthesizing translations

The synthesis stage of meta-ethnography is an iterative process and is determined by the previous step; by how the studies are related to one another (Noblit & Hare, 1988). By reading and rereading the studies, it was possible to establish that the studies were not refutations of one another and that there was a significant overlap of concepts from each study. Thus, a refutational analysis was not carried out. The relationships between the studies appeared to be reciprocal, from which a line of argument synthesis could be developed. A line of argument synthesis "recognises that people study different aspects of phenomena and that it might be possible to offer a fuller account of phenomena by arranging the metaphors from each study in some order that allows us to construct an argument about what [the studies] say" (Thorne, Jensen, Kearney, Noblit, & Sandelowski, 2004, p.8).

TABLE 3: Developing third order constructs			
Third Order Constructs		Example First and Second Order Constructs	Studies That Include 2nd Order Constructs (Study numbers are given in table 1)
Key Concepts	Themes		
Activating Choice	Identity	"identity…component of recovery… the work of rebuilding a functional self… a person apart from the reality of the illness"	5, 7, 8, 9
	Adaptive preferences	"adaptive preference for a social or leisure activity…are insufficient to support a person's recovery"	4, 2, 8
	Exercising choice	"…real and meaningful choice…consumers are empowered to lead decision making but also that a variety of choices exist, underscoring the need for a resource rich environment"	1, 2, 3, 4, 5, 6, 7, 8, 9, 10
Systemic Barriers to a 'Good Life'	Powerlessness	"I feel like I'm being pushed from person to person to person and place to place to place" feeling pushed, disempowered, isolated rather than socially connected & empowered	2, 7, 9
	Invalidating rules	poverty discussed as a barrier to belonging… [as is] participating in community activities that cost a fee	9, 4, 2

	Stigma	stigma… described as an external force negatively impacting on the opportunities, wellbeing and health of the participants	6, 7, 9
Mobilising Empowerment through safe contexts	Taking control over own environment	thought, practical reason and material control over one's own environment – exerting control and agency.	3, 5, 6, 9
	Resources	"I think its access to resources, to health care, to medication… access to counselling… It's being able to afford to come to appointments…"	1, 2, 3, 4, 5, 6, 7, 8, 9, 10
	Ownership of improvement	"I've worked for it, I've done something toward my improvement… not 'I received, I received, I received'"	2, 3, 6, 8
	Expansion of functionings	professionals can sometimes provide the basis for expanding Capability… [by] reconsidering employment functionings… leading to potential for new functionings and valued social outcomes	2, 4, 9
Connection as Healing	Reciprocity	accountability for their peers gives them a sense of worthiness	1, 2, 8
	Self-respect	"everyone deserves housing"	2, 3, 4, 6, 9

	Connecting Capabilities	connectedness provides companionship, good feeling but also resources	4, 5, 7, 9

Meta-ethnography: how the papers are related

The scope of the review was to gather together peer-reviewed pieces of research, which had applied the CA in some way to further the understanding of PMH and how services are conceptualised, developed or provided. Early on in the meta-ethnography, once the final 10 papers had been gathered from the systematic search, it became clear that there were papers which had applied the CA to interpret a piece of qualitative work retrospectively, papers which have used the CA to design and inform a piece of qualitative work, and papers which had used the CA to design, inform and interpret a qualitative piece of work. The latter group of papers were classed as 'key papers' as they presented conceptually rich and valuable data to the review. The other papers were less conceptually rich but offered a valuable source of data to the review, nonetheless.

Synthesising Translations

The meta-ethnography drew on the experiences of 688 individuals, from six different countries across ten separate studies. The analysis led to four key concepts, built up from 14 themes and concepts into third order interpretations: 'activating choice', 'systemic barriers to a 'good life'', 'mobilising empowerment through safe contexts' and 'connection as healing'. Four of the studies contained most or all of the concepts. All the remaining studies contained at least three.

Activating Choice represents the ways in which services facilitated choice for service users, or the way in which participants made a choice about either their treatment, recovery process or environment which impacted the participants' mental health. Participants voiced different ways they went about this, and services reflected on the systemic influences on how choice was enabled for service users.
This excerpt from Ware, Hopper, Tugenberg, Dickey, and Fisher, (2007, p.472) is an example of this key concept from a system level: "[the] importance of meaning making [for the service user] … 'what counts' [in terms of recovery] as recovery-oriented policies and services".

Benbow, Rudnick, Forchuk, and Edwards (2014, p.1055) reported the difficulty for services in creating space for meaning making, and 'what counts' when making decisions, due to a lack of adequate policies in place to ensure access to informed choices and decisions, describing: "[there is] maltreatment at a societal level… in the lack of policies that are supposed to… ensure equitable access to resources and services" and in Brunner (2017, p.164), a participant described how making a choice about his employment was curtailed by his Doctor: "I would like a job, but the doctor says that I can't do it". The difficulty in activating choice from the examples in the literature seems to suggest that a combination of inadequate resources, a lack of equity at a policy level, and professionals who passively curtail the freedom of service users by failing to take into consideration 'what counts' for the individual.

The availability of resources opened up a number of options through which a service user was able to expand their capability set: "creative and therapeutic activities… had

offered a glimpse of new capabilities" – Brunner (2017, p.164), but the prospect of returning to 'real life' threatened this newfound capability set: "the worst case scenario... [would be] going back to the same kind of work" which the participant described succinctly in this quote: "I've just found the… bike and music course… it took me this long to get back into wanting to live again and wanting to get out... never mind spending all day in a dark dingy warehouse collecting boxes". Petros, Solomon, Linz, DeCeraris, and Hanrahan (2016, p.274) described how there is a need for "real and meaningful choice" when it comes to decision making and that service users should lead in decision making: "[service users] are empowered to lead in decision making, but also [knowing] that a variety of choices exist, underscoring the need for a resource rich environment".

There are examples in the literature where limited resources have been in place and even though the service user led decision making, it resulted in the service user making choices based on 'adaptive preferences' based on a limited set of options. This, in turn, negatively impacted the service users mental health and created an invalidating lived experience: "things are just going against me…. It's my paranoia" (Petros et al., 2016, p.271). A lack of resource in this instance was reframed as a personal failing for this service user, and can create a sense of 'stuckness' for others: "you are stuck between what do I buy? - groceries or meds? [medication]".

Professionals can sometimes engage in "positive reframing" lack of resource, and inadvertently encourage service users to limit their choice and options, and normalise restrictive environments. One service user described how they had been sent to a

support group as treatment, but which didn't match their needs: "the resources are there… but they're not meeting the needs of everyone" and when support staff focus on returning to work and getting a job, regardless of whether it interested the service user or not, this was experienced as a threat to an emerging sense of wellbeing for the participant: "you get quite a lot of freedom when you're mentally ill… I've got freedom to come here [to a creative activity program] and play a drum… suddenly [with a job] that could all be snatched away". Another example of limited choice and resource are service users who are living in poverty: "sometimes because of the poverty, you want to commit suicide" (Benbow et al., 2014, p.1052). Lack of choice combined with a lack of resources can lead to a sense of feeling trapped and exacerbate mental health difficulties.

When there are adequate resources available, choices can be made that more accurately reflect the needs of the service user. In Meintjes, Field, Van Heyningen, and Honikman (2015, p.245) example, they identified how activating capabilities using mental health care enabled a variety of choices and options for women to "identify their own conception of good" by enabling physical and mental space to engage "thought, practical reason and material control over one's own environment". Sachetto, Ornealas, Calheiros, and Shinn, (2018, p.59) notes the role of choice in empowering service users as exemplified by the quote: "participation, choice and power sharing exercises are potential means to promoting empowerment".

Systemic Barriers to a 'Good Life' represents the many hurdles and challenges that participants have to face when seeking treatment, undergoing treatment or while in

recovery from experiences of mental distress. Of all of these hurdles, powerlessness created by structures and services formed a consistent theme throughout the papers. In Petros et al., (2016, p.270), one participant talked about feeling trapped and hemmed in as a result of enforcement of mandatory attendance to a set of classes they had no interest in "I'm stuck, trapped here... some days I just don't feel like it" another participant echoed this dilemma "I have to go to the program, or they'll kick me out of the shelter". For other participants, resources were a significant barrier, leading to feelings of powerlessness when faced with limited options "[need for] access to resources, access to healthcare, to medication… access to counselling… it's being able to afford to come to appointments" (Mall, Honikman, Evans, Swartz, & Lund, 2014, p.1097). This is reflected in a similar report from another paper: "due to poverty [service users] could not take care of themselves and could not access the resources needed" (Benbow et al., 2014, p.1052). Evidence emerging in this review suggests that having a limited set of choices as a result of a lack of resource has a detrimental impact on mental health. Participants were clear about what they felt they needed to challenge the effect of powerlessness and 'take back control' of their lives: "goals [focused on] establishing and maintaining relationships... seeking and maintaining financial independence, participating in education and employment and fulfilling obligations to others… or generally being able to survive and flourish in the community" (Light et al., 2016, p.39).

Many papers reported on the stigma faced by individuals either as someone with "mental health issues" or the challenges faced by an individual "in recovery" and having to adjust their expectations based on a new set of rules for living. One couple

shared their sense of acceptance over not having children, having been discouraged by the experiences of their peers: “we knew we couldn’t have any kids… [we] knew people who was schizophrenic and had their kids taken off them because they couldn’t watch them” (Brunner, 2017, p.165). Here, stigmatising narratives about people with mental illness and their perceived competence (or lack of) to raise children denied this couple the potential for a future supportive familial relationship.

Participants also showed evidence of internalised stigma, as one reported “I am disgusted with myself too” here the emphasis on the ‘too’ as the disgust is perceived to already exist in the world, toward the individual. As described by Benbow et al. (2014, p.1052) “stigma….a force negatively impacting on the opportunities, wellbeing and health of the participants”. An example of that ‘external force’ reported in Lavie-Ajayl et al. (2018, p.7) found that the “implicit beliefs of GP’s [about their patients] have negative consequences for the capability set of people living with severe mental illness by limiting or reducing access to elements of healthcare and personal conversion factors based on an implicit bias about the mental status of the service user”.

Invalidating rules enforced by services can be seen as harmless or at least well-intentioned, but can curtail individuals freedom and opportunity for choice. For example, a participant described how support staff would encourage “[him] to go out all the time” ignoring that this individual had a rich and varied indoor life that he was happy with. Encouraging service users to engage with the community can be a helpful strategy, but this can also create problems particularly when community

activities or resources cost a fee or ignore creative and fulfilling endeavours already in use by the individual. Some participants reported having to make a choice as to whether they could afford to travel to appointments, eat food or take medication, depending on their financial resources. Encouraging service users to further stretch their budgets on community activities is unlikely to be conducive to expanding their individual capabilities set; "the medical-ethical principle of informed choice only exists if people have alternative choices that they are able to pursue" Brunner (2017, p.166).

Mobilising Empowerment through Safe Contexts represents the successful interaction of environments and contexts that encourage choice, agency, expansion of capabilities, and are adequately resourced. Meintjes et al., (2015, p.247) describes the liberating and expansive influence that antenatal counselling had for a group of women living in South Africa: "activating women's adaptive capabilities through mental health care can increase resilience, agency and productivity… and facilitate the conditions needed to alleviate poverty". Light et al. (2016, p.41) report that "the narratives [of participants] suggest that treatment should restore and scaffold fundamental capabilities for a 'good life'". Brunner (2017, p.162) concludes that when services don't challenge the status quo and fail to take into account individual context, things remain the same or get worse: "placing people back into the same situations… maintaining the same functionings… creates the same outcomes [as before]". A participant in Mall et al. (2014, p.1097) summed up the need for emphasis not just on resources, but context as well: "we have this mentality… if you do not have food then I must give you food… but we need to empower women to produce

food and find the means to improve their situation... it's not about food, it's about improving the situation". Emphasis was put on the ability to exert control and choice over the means and production of resources. It was later referred to "I've worked for it, I've done something toward my improvement, not 'I received, I received, I received'". Of note here was the emphasis on 'my' improvement – suggesting the participant felt a sense of ownership and autonomy about their overall wellbeing, which led to a sense of empowerment. In a community mental health setting the idea of enacting agency as a route to empowerment was noted in Brunner's (2017, p.162) paper: "...people use their agency to manage feelings of distress… they're not passive recipients of professional support". Participants were keen to 'pitch in' and contribute toward their sense of recovery: "you need to put in a lot of hard work yourself". In Meintjes et al. (2015, p.245) the importance of material control was noted: "being empowered to take material control over their lives, women are able to reorient… towards support …and respect".

Connection as Healing represents the ways in which participants found opportunities for healing by connecting with other people, support networks and with their own identities. Ware, et al. (2007, p.471) notes that not only does companionship provide a "good feeling" and a form of social support, but can provide access to resources. Lewis, Hopper, and Healion, (2012, p.5) found that in a community support program, service users were responsible for one another's attendance and had accountability for their peers, which produced a sense of worthiness. Participants described the program positively: "like a family" and: "this is the first time in my life I have felt connected". This mirrors an aspect of a previous concept, systemic barriers to a good

life, where service users were denied familial ties due to stigma and bias about their capabilities. In this example, service users were able to create those ties within a supportive environment, scaffolding by adequate resources and a framework which enabled decision making about their treatment.

In environments that weren't conducive to building connection, one woman exercised an adaptive preference to isolate herself "I'm quiet, I mind my own business" (Petros et al., 2016, p.268) and although this maintained her sense of bodily integrity, it reduced her ability to socialise and build a sense of social support. The role of environment extended out into the community, with one participant describing "this is a really rough area [that they were housed in]… not a nice... town... not a nice place to live actually" the resignation over this lack of choice around accommodation and a restrictive environment led to a sense of disempowerment, a sense that actively opposes recovery. Having support in the form of an advocate was empowering for a number of individuals, who described how at times they needed someone to speak for them when it came to complex matters: "you can't speak for yourself... an advocate has to speak for you" but the significant difference being the choice to hand over her own voice to someone else, versus being silenced or spoken for. The experience of living in a supported environment, being able to exert control and have agency over his day to day life, led one participant to note that "everyone deserves housing" – a short sentence but representative of the realisation that they, and others, were entitled to care and to adequate resources to lead a life worth living.

Line of argument synthesis

Following the process of synthesis and translation in this review, it is possible to see how principles from the CA can be directly applied to the provision of PMH services. The narratives from the papers included in this review emphasise the role of choice, in the presence of adequate resources to engage and maintain a sense of agency for the consumer of public services. When this flexibility of choice is not available a service user may engage a set of adaptive preferences to 'make do' in the short term, but these are ultimately unfulfilling and can lead to feelings of disempowerment and potentially, increased mental distress. The Capabilities Approach emphasis on systemic factors encourages a critical gaze toward social policy and management of public services, to assess what could be done differently to expand services users' capabilities so that they can flourish rather than just 'make do' with an unfulfilled life.

Discussion

The synthesis of ten papers has shown how expanding the capabilities set for people who have experienced mental illness or distress relies on a number of processes at a systemic and individual level. An ability to name and develop preferences in the presence of adequate resources is one of those processes, as well as flexibility and room for choice built into service provision at a policy level. There are a number of Nussbaum's (2011) 'combined capabilities' (Life, Bodily Health, Bodily Integrity) which correspond to the 'deficiency' needs within Maslow's hierarchy of needs (Maslow & Lewis, 1987). These capabilities are often denied to people who experience mental distress, in the way that their opportunities, individual choice and preferences are often reduced by public services. Many of the narratives contained in this review note how lack of resource (whether that is food, shelter or healthcare) severely limits a person's ability to lead a 'good life' that they subjectively value and it seems from the literature that individuals who experience poor mental health are disproportionately affected. Some papers described how social policy that limits freedoms can encourage habituation to an unsatisfying life. Some services or professionals can communicate in a way to positively 'reframe' dire circumstances and inadvertently limit an individual's progress to a life they subjectively value.

The ability to discover and develop 'adaptive capabilities' (meaningful choices based on subjective wellbeing) rather than 'adaptive preference' (limited choice based on inadequate resources) seems to contribute to meaningful recovery following a period of distress or mental ill-health. It also seems to act as a protective measure against

future stresses and strains from the demands of everyday life. The distinction between making a choice based on limited resource and a choice based on meaningful options could be useful for auditing service provision currently, and the development of service pathways and delivery in the future. It could also be useful for professionals to consider when asking service users for their consent, or making onward referrals to other agencies and services, to reflect on whether the client is basing their choices on what they need and value, or whether they're expressing a preference based on a limited set of options. In the same way it is important to check for understanding, it could also be useful for professionals to check for adaptive preferences versus adaptive capability. Part of the future role of mental health services could be to deliver the social basis of capabilities (Nussbaum, 2011) to offset the advantages that others may have in pursuing a 'good life' such as health, wealth, or just luck.

Another significant theme from the literature in this review is an emphasis on the role of stigma and discrimination faced by service users from the law, by healthcare providers and by some members of the general public. In some cases, the narrow, normative perceptions that people had of the abilities of individuals experiencing poor mental health were fulfilled by the limited availability of social supports and individuals enacting a limited set of adaptive preferences. Ultimately this led to feelings of resignation, avoidance and disconnection from the community in which they lived. In other cases, acquiescence to rigid rules and limited freedoms led to feelings of self-blame and shame for their experiences.

The CA offers a conceptual framework for PMH based on equity and accessibility regardless of gender, socioeconomic status, sexuality or minority status. The approach seems to suggest a way to develop supportive contexts which encourage personal growth and development while recognising the role of systemic barriers to curating a 'good life'. This seems to be particularly relevant given that many European countries have adopted austerity policies since the 2008 financial crash and the negative impact on the health and wellbeing of citizens (Bezruchka, 2009). This includes an increase in alcohol-related deaths (Stuckler, Basu, Suhrcke, Coutts, & McKee, 2009), an increase in reported mental health difficulties (Quaglio, Karapiperis, Van Woensel, Arnold, & McDaid, 2013), and increasing health inequalities (Stuckler et al., 2009).

As funding for services such as housing, education and employment is reduced, those at risk of social exclusion are also at risk of health deterioration (Sharma, Dwivvedi, & Seth, 2013). The CA emphasises that individuals require choice and meaningful options in order to lead a 'good life' and achieve a good quality of life. When evaluating health or social policies, the CA argues that it is crucial to also evaluate how people can make use of available resources given their personal circumstances, rather than measuring wealth, or 'primary goods' (e.g.: income) (Rawls, 1999). The CA recognises that cuts to welfare spending significantly reduce the practical resources available to citizens, and so reduce individuals' capabilities. The CA could enhance measurements of wellbeing including elements such as living standards, life expectancy, as well as adopting health outcomes as a key part of policymaking. By utilising a CA informed evaluation method, opportunities for improving services

become available by identifying gaps in service provision (due to lack of resource or freedom to choose) and also adding depth to 'what works' by exploring the choices people make when accessing support services, which can, in turn, improve the reach of health promotion agencies. Rather than relying purely on statistics to measure the success of health policies at a macro level or service outcomes at a meso level, the CA suggests there is an ethical, moral responsibility for agencies to justify service provision or policy based on determinants of health and wellbeing that would not normally be considered.

Implications for future work could include piloting the ten 'central capabilities' as a way of qualitatively measuring individuals opportunities for choice and agency in their own lives, particularly groups of people who are typically marginalised by services currently, or who historically struggle to access mainstream services, such as people experiencing homelessness, disability or with experiences of addiction.

Strengths and Limitations

One of the main strengths of the review is the breadth of evidence from different countries and cultures, with different legal systems and healthcare providers. Despite these various differences, there was consistency between papers in the way authors had conceptualised mental health difficulties both from an individual and system level, and consistency with how the CA had been conceptualised and applied in a variety of different ways. One limitation of including a diverse range of countries, however, is the emphasis in some papers on cost and access to healthcare in that

particular country, which does present significant challenges in countries with different models of healthcare. There are many sources of inequality in terms of how health and mental health services are provided in each of the countries included in the review (Rhen-Mendoza & Weber, 2018). Despite the legislative and political differences between countries, the themes from each remained similar throughout the papers.

The CA literature is in its nascent stages, particularly regarding its application to health, and even more so with its application to mental health. There is more literature on the potential application to mental health and mental health services, but for the purpose of this review it was useful to focus on how the CA has been practically applied. Considerable effort was spent in the early stages of the review developing as broad a search as possible to return relevant material but not so broad that the search became impractical, returning high numbers of irrelevant results. A source of difficulty was the lack of indexing in databases for terms relating to the CA, such as 'functionings' and 'flourishing'. In this paper, only papers published in peer-reviewed journals were included, any relevant work in the 'grey' literature or book chapters was not included.

The meta-ethnography approach was chosen as a suitable method for synthesizing qualitative literature, while preserving meaning and context from individual sources of data. Although the approach is widely used for qualitative systematic reviews, there are significant differences in how the approach is applied between authors, and as such this review has attempted to stay close to the work of Britten et al. (2002).

The process of ‘translations’ and ‘synthesizing translations’ is creative, personal, and susceptible to bias of the researcher. Having a second researcher to reflect on the development of themes and key concepts was helpful, but the synthesis is interpretive and another researcher may have drawn different conclusions from the data in the papers presented in this review.

A challenge to synthesizing qualitative work is attempting to bring together multiple data sources from different papers, which used different methods. To facilitate this process, this review has been influenced by the symbolic interactionist epistemological stance (Burr, 2018) of looking for social definitions (as reported by participants and authors of each paper) around mental health and mental health services. The review has sought to look for the meanings and develop a shared understanding between papers. Another challenge was the CA itself, which can appear to be a nebulous theoretical framework and difficult to ‘pin down’ in terms of application. This is evident in the wider literature in terms of how, when and why the approach is applied in different contexts, across different disciplines.

Conclusions

This meta-ethnography has brought together and synthesised a body of literature completed so far in relation to the application of the CA concerning mental health and mental health service provision. The key concepts of 'activating choice', 'mobilising empowerment' 'systemic barriers to a 'good life'" and "connection as healing" emerged from the literature reviewed. These concepts can contribute to equitable and effective PMH services which encourage personal growth and healing from psychological distress. Application of the CA to PMH services would require changes to the way services and public agencies are funded, and changes to the way social policy is currently written and enacted at a legislative level. However, within this review there are suggestions for ways professionals can enact change at a 'micro' level by finding opportunities for 'adaptive choice' and personal agency for service users where possible. By acknowledging the significance of systemic barriers to change and to wellbeing, there is a shift in responsibility to policymakers and an onus on government departments to seriously consider the gap between what they currently do and what they could do to facilitate transformative change and create supportive contexts for individuals who experience mental distress.

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Chapter 2

Research Paper

The lived experience of seeking support for people with a history of homelessness and drug or alcohol addiction - A Qualitative Research Project

Word Count: 15007

Empirical paper to be submitted to the International Journal of Qualitative Studies on Health and Wellbeing

Abstract

Background

Research has demonstrated the multiple systemic factors that can lead to homelessness and the resulting detrimental impact that homelessness has on physical & mental health. By drawing on the lived experience of service users and professionals working within homelessness services, this project seeks to examine to what extent people have the freedom to create a 'good enough life', using the resources available to them.

Methods

In phase one, eight individuals participated in semi-structured interviews to discuss their experiences of seeking support while homeless and using drugs or alcohol. These interviews were analysed using Interpretive Phenomenological Analysis (IPA). The second phase included eight professionals in two focus groups, which looked at the emerging themes from the interviews and asked what barriers existed to providing 'good enough' services for homeless people currently. These focus groups were analysed using Thematic Analysis (TA).

Findings

Three 'master themes' encapsulated individual interviewees' experiences of seeking support; 'Sense of self smashed by the streets', 'Supports can help or hinder' and 'Asserting the self: 'I know what I need''. Three themes were identified from focus groups with professionals; 'Professional 'hoops'', 'Barriers to good enough services', and 'Caring for complexity'.

Conclusions

Participants' narratives revealed several converging themes, particularly around the barriers to seeking support and the corrosive effects of working within systems which inadvertently diminished their sense of self, and personal agency. The role for services to improve provision of support is outlined at the conclusion of this paper.

Introduction

"A home provides roots, identity, a sense of belonging and a place of emotional wellbeing. Homelessness is about a loss of these" – Crisis (2003, p.2)

Homelessness is not just about a lack of a house, it also reflects the lack of a home; the physical, spiritual, emotional, territorial and ontological qualities that make accommodation safe, supportive and meaningful for an individual (Somerville, 1992). Since the 2008 financial crisis, the number of people living in temporary or insecure conditions has increased. Official figures in the U.K. for 2017 showed an increase of 44% for homelessness applications (Fitzpatrick, Pawson, Bramley, Wilcox & Watts, 2017). However, these figures only capture people who engage with statutory services; the actual number is likely higher. As many as 63% of homeless people are hidden from official statistics (Reeve & Batty, 2011). Schemes to tackle homelessness are often seen as a way to ease pressure on oversubscribed social housing and avoid 'damaging' homeless statistics (Homeless Link & St Mungo's, 2012). This can mean that people struggle to access these services (Lund, 2011) and therefore rely on hospitals and A&E departments as primary sources of health and social care (Hwang, Weaver, Aubry & Hoch 2011), placing an increased financial burden on health services (Salit, Kuhn, Hartz, Vu, & Mosso, 1998).

Homelessness is recognised as a significant health issue (Hewett, Halligan & Boyce, 2012). Material deprivation, coupled with multiple social exclusions, is directly linked to determinants of health (Wilkinson & Marmot, 2003). People experiencing

homelessness have disproportionate rates of chronic and long-term illness (Zlotnick & Zerger, 2009), poor oral health (Collins & Freeman, 2007), higher rates of mortality (Morrison, 2009) and higher rates of mental health difficulties and brain injury (Stone, 2018). Homelessness is associated with the concept of 'tri-morbidity', where physical health can be further complicated by difficulties with mental health and alcohol or drug addiction (Hewett, Halligan, & Boyce, 2012) as well as the adverse effects of homelessness itself, such as injury, trauma, inhospitable living conditions and violence (Khandor & Mason, 2007). Homeless people are psychologically impacted by repeated exposure to trauma, violence, stigma and stress, leading to feelings of powerlessness, low self-esteem and poor social relations (Bolam, Hodgetts, Chamberlain, Murphy, & Gleeson 2003). Degradation of potentially supportive social networks is made worse by the stigma of being homeless as well as the public perception of homeless people as "dangerous, dirty and obscene" (Farrugia, 2010). This can leave homeless individuals feeling ashamed, worthless and withdrawn from society (Kidd, 2007). As a way to manage the impact of these feelings and the loss of a sense of identity, homeless people may use alcohol or drugs to cope (Williams & Stickley, 2010) as well as to suppress mental and emotional pain (Goering, Tolomiczenko, Sheldon, Boydell, & Wasylenki, 2002).

Homelessness is not a situation in which people unexpectedly find themselves; rather, it is a process, with clear antecedents (Hodgetts et al., 2007). The interaction of systemic (macro) factors and individual (micro) factors as precursors to homelessness has been well documented (Toohey, Shinn, & Weitzman, 2004). Researchers have explored the interplay of social policies such as austerity or lack of affordable social housing with personal circumstances, such as trauma and neglect,

mental illness and alcohol or drug addiction (Morelli-Bellai, Goering, & Boydell, 2000). Once homeless, people can struggle to access support from public agencies, with mainstream statutory services either actively excluding people (Lamb & Joels, 2014) or creating a set of arbitrary barriers under the guise of requiring 'readiness' to access services (Harper, 2014). Psychological service provision can often take an individualising approach to distress, meaning that the needs of homeless people are 'invisibled' or masked by reasons for exclusion such as 'failure to engage' (Harper, 2014). In England, various attempts have been made to integrate care for homeless people at a policy level, such as the Department of Health's Homeless Hospital Discharge Fund (Dept of Health, 2011) or Pathway Model of Integrated Care (Albanese, Hurcombe, & Mathie, 2016). The Homelessness Reduction Act 2017 was introduced as a set of preventative measures to provide support to people at risk of becoming homeless, with some limited positive effects (Fitzpatrick et al., 2019).

Strategies focused on housing, such as Housing First (Padgett, Henwood, & Tsemberis, 2016) and the implementation of Psychologically Informed Environments (Johnson & Haigh, 2010), have shown to be effective in supporting people who are homeless and have complex needs (Keats, Maguire, Johnson, & Cockersell, 2012) but have not been widely implemented in the UK (Haigh, Harrison, Johnson, Paget, & Williams, 2012).

The pathways out of homelessness can be varied (Anderson & Tulloch, 2000) and problems such as social isolation, loneliness and a lack of community integration can mean people return to homelessness after being housed (Warnes & Crane, 2003). The meaning-making ascribed to becoming 'housed' seems as essential as the

material resource of a house itself yet is often neglected by services and researchers (Snell & Hodgetts, 2007). Successful support programmes include the opportunity for choice as a key part of their service provision (Tsemberis, 2003). Choice in housing, education and employment, as well as support in making decisions, encourages a sense of freedom and agency often lacking in mainstream services (Ornealas, Moniz, & Duarte, 2010; DeVerteuil, 2011).

People experiencing homelessness often have multiple and complex needs which result in deep social exclusion (Fitzpatrick et al., 2007) and these multiple exclusions, including stigma and discrimination, can mean that this population is seen as being 'hard to reach' in terms of research and practice (Liamputtong, 2007). It is difficult to define 'hard to reach' in physical and mental health services without acknowledging the broader systemic issues that can make services hard to reach for the service users. Service restrictions and limitations may mean that it is the services themselves that are 'hard to reach'.

Aims of the Study

The primary aim of the current study was to explore formerly homeless people's experiences of seeking and receiving support. The researcher aimed to get an 'insider perspective' of the systemic determinants of homeless as well as look at the ways in which individuals had navigated practical, personal and systemic barriers to recovery. A secondary aim was to examine how individuals' support-seeking experiences can inform future clinical and community work to help make 'hard to reach' services more accessible to those who experience multiple barriers to support.

Method

Design

Interpretative phenomenological analysis (IPA) (Smith, Flowers, & Larkin, 2009) was used for the 1:1 interviews and thematic analysis (TA) for the focus groups (Braun & Clarke, 2013).

Recruitment

A local non-NHS, third sector community interest company (CIC), NeuroTriage, which serves as a support organisation for homeless individuals, agreed to help access potential participants. Using purposive sampling (Smith et al., 2009), advertisements for the study were shared through appropriate social media networks and in print in the 'homeless hub' (Appendix B & C). The 'hub' became a focal point of the research, thanks to the goodwill and support of staff working in homelessness services across Merseyside.

Inclusion and exclusion criteria

A local third sector organisation was identified as a suitable site for recruitment. The 'Homeless Hub' is a drop-in service where homeless people from across the city can access help and support and continue to access help once they become housed. To take part in the 1:1 interviews, individuals had to have experienced both homelessness and substance addiction within their lifetime, to have sought support from others for these issues, and to identify as being in a state of 'recovery'. To take part in focus groups, participants had to be professionals working within the field of

homelessness, without lived experience of homelessness or addiction. Staff working in the homeless hub were able to inform service users of the study and refer individuals that they felt were suitable. Individuals were excluded from taking part in the study if they were actively using substances, or currently experiencing street homelessness.

'Support' was defined as any attempt to seek practical or emotional help or advice, regardless of source. *'Homeless'* was defined as the experience of not having a secure place to live, not being able to live at home due to the risk of violence or threat, or not having a home due to financial difficulty (Reynolds, 2018).

Participants

Sixteen participants were recruited in total. Eight individuals who had experienced homelessness participated in 1:1 interviews and eight professionals took part in the focus groups. This is considered an appropriate sample size for a doctoral-level research project (Smith et al., 2009). Details about the interview participants can be seen in Table 4, overleaf. To protect anonymity, focus group demographics were kept brief. Participants included two males and six females. Professionals came from a variety of backgrounds including public health, housing agencies and the third sector.

Table 4: Anonymised Interview Participant Demographics			
Name	Gender	Age Range	Recruited via
Kayla	Female	40-50 yrs.	Keyworker
Kelly	Female	40-50 yrs.	Advertisements
Kate	Female	40-50 yrs.	Keyworker
Matt	Male	50-60 yrs.	Keyworker
Simon	Male	30-40 yrs.	Keyworker
Jim	Male	30-40 yrs.	Advertisements
Dave	Male	40-50 yrs.	Advertisements
Liam	Male	30-40 yrs.	Keyworker

Data Collection

The focus groups and interviews were recorded using an audio recording device and transcribed by the researcher. Identifiers were removed and pseudonyms used to preserve confidentiality.

1:1 Interviews

Recruitment for the interviews was coordinated by the lead researcher during several informal meetings at the hub, where potential participants were shown the advertisement and talked through the aims of the study, what was involved and how to get in touch with the lead researcher – either directly via email or through an existing network of key workers. Appointment cards were useful at this stage. Interview 'slots' and contact information was disseminated to people interested in

participating with a clear reminder of whom they were seeing and at what time. Copies of the information sheet and consent form were made available and discussed with anyone interested in taking part. The researcher checked for understanding and consent at each step.

Interviews were conducted at participants' convenience and lasted between 60 and 120 minutes, including breaks. Interview length varied due to the particular accessibility requirements of each participant. Participants were reminded that the interviews, which had the potential to be distressing, could be paused or terminated at any time. Staff members at the hub offered emotional support for participants if needed. The organisation is a confidential service, meaning participant anonymity was assured at all times. Participants were debriefed and given a £20 voucher as thanks. Reasonable adjustments were made for participants such as comfort breaks and opportunities to ask questions. The interviews followed a semi-structured outline (Appendix E & F), using prompts where appropriate. The outline was created with cooperation from the EbE with the intention to be sensitive to the needs and vulnerabilities of the participants and to avoid the sense that this was a 'data raid' (Wadsworth, 1984). The amended interview schedule served as a flexible guideline for each interview, ensuring consistency without adhering to a strict, formal series of questions which could have extinguished participant reflections and insights, and left space for a better understanding of what participants had seen, felt and heard (Miller & Tewksbury, 2001).

Focus Groups

Focus groups took place after the 1:1 interviews. The groups were advertised throughout an established network of professionals familiar with the study, on social media and in print in various homelessness services across the area (Appendix B & C). Attendance was open to any professionals who worked within homelessness services, across disciplines, regardless of qualification or position held. Interested participants were excluded from participating if they had lived experience of homelessness. The original aim for the focus groups was to have professionals feedback on their experiences of providing support, reflect on the emerging themes from the 1:1 interviews, and for one focus group to provide their views on applying a framework to their professional work. In practice, the focus group discussions focused on the lived experiences of professionals and the emerging themes, topics which participants were clearly very passionate about. As a result, both focus groups covered near-identical topics, and so both transcripts were analysed as one.

Participants completed the consent form and agreed to their data being used anonymously in the study. Focus groups lasted between 90 and 120 minutes. Recordings were transcribed by the researcher and anonymised. A semi-structured protocol was used for each focus group (Appendix F) and applied flexibly, allowing participants time to reflect and pause, avoiding the researcher 'leading' the discussion too formally and allowing for a natural 'flow' of conversation (Smith, et. al 2009). Participants were provided with a set of themes from the interviews (Appendix H). The first focus group discussed the challenges and hurdles of providing 'good enough' services currently, and what factors participants felt would help or hinder

their work. The second focus group discussed the same topics as the first, as well as a brief discussion about the challenge of applying methodological frameworks to their practice.

Expert by Experience (EbE) involvement

The value of incorporating service users into research is well-documented (Hanley et al., 2004). An 'expert by experience' (EBE) was recruited to act as a consultant on the project following approval by the university ethics committee. Tim Noble contributed input into an amended, accessible consent form and information sheet, Interview Schedule and advice and guidance on recruitment and engagement of participants. He was compensated for his time spent on the project and consented for his name to be used in this piece of research.

Ethical Considerations

From the outset of this project, the lead researcher was keen to create advertisements, consent forms, information sheets and interview schedules which were accessible and attractive to participants. It has been noted in other studies looking at the experience of marginalised groups that there is a need to compromise some of the specific requirements of methodology or procedure to ensure the research process does not do harm or risk further marginalising already vulnerable people (Pyett, 2001). The standardised consent form and information sheet templates were adapted to make them easier to read, guided by feedback provided by the EbE. This was done to ensure participants had multiple opportunities to query or opt-out of the study, allow for different levels of literacy, as well as avoiding

participant acquiescence or assumption of consent from the researcher. This study was granted ethical approval from the University of Liverpool and Life Sciences Research Ethics Committee (Appendix A) and was awarded university sponsorship.

Reflexive Statement

Malterud (2001, p.484) states that: "*Preconceptions are not the same as bias unless the researcher fails to mention them"*. While the researcher has no experience of homelessness, there is a history of alcohol and drug addiction in his family. In order to be aware of his preconceptions, the researcher used a reflective diary and supervision to unpick which elements of the analytical process may have been vulnerable to his bias. An example of this would be the potential to lean into assumptions or bias based on personal motivation when analysing themes around accessing support and being denied help from statutory services.

Data Analysis

1:1 Interviews

IPA is the appropriate methodology for analysing these interviews, which were intended to focus on participants' experiences of support seeking (Gibson & Hugh-Jones, 2012). This phenomenological method of enquiry is underpinned by concepts derived from phenomenology, hermeneutics and idiography (Smith & Osbourne, 2008). It employs the 'double hermeneutic'; wherein the researcher explores participants' meaning-making of their experience, combined with the researchers making sense of the participants' meaning-making. IPA studies use a small, purposely recruited sample, for whom the research question is relevant (Smith et al., 2009). It is a rigorous methodology for analysing data which recognises the inherent interaction between researcher and participant (Smith et al., 2009). The result is, therefore, an interpretation of participants' phenomenological experiences of support-seeking as people with experience of homelessness and alcohol or drug addiction.

The researcher immersed themselves in the data by reading and rereading each transcript. Initial reflections, observations and notes were made on each transcript, which was then developed into emergent themes (Appendix J). Emergent themes were then grouped into first subordinate and then superordinate themes. Themes tended to be more descriptive in the early stages of the analysis and later became more conceptual. Once every interview had a list of superordinate themes, these were combined across all cases and grouped into 'master' themes (Smith et al., 2009). This process was reflected on in supervision with the primary supervisor throughout.

Focus Groups

Audio data from the focus groups was analysed using thematic analysis (TA) (Braun, Clarke, Hayfield & Terry, 2019) comprising of six stages of coding and development of themes. Thematic analysis was thought to be the right choice of method as it allows flexibility and is appropriate for exploring in-depth data from focus groups (Braun & Clarke, 2013). Transcripts were read and reread to become familiar with the lived experiences of the professionals. Initial codes were developed and grouped into emergent themes (Appendix I). A hierarchy of themes and sub-themes was established and revised to ensure all themes were supported by the data.

Validity, reliability and rigour

Yardley's (2000) guidelines for assessing the quality of qualitative work (sensitivity to context, commitment and rigour, transparency and coherence, impact and importance) were applied throughout this study. A reflective diary was maintained by the researcher as a way of monitoring insights, comments and reflections, particularly during analysis, offering reflective validity. Transcripts, initial notes, coding, observations and reflections were shared with the primary supervisor throughout the study and reflected upon, to ensure a degree of transparency and thus ensuring validity and quality of the final themes.

Findings

1:1 Interviews

The purpose of this study was to explore the experiences of support seeking for people who have been homeless and have experienced drug or alcohol addiction. Three master themes were identified through the analysis of the interviews. These are presented along with their corresponding subthemes in Table 1 below. Master theme titles include quotes from participants to ensure themes remain grounded in the data.

Table 5: Master themes for 1:1 Interviews

Master Themes	Superordinate Themes
Sense of Self Smashed by the Streets	• Loss of Integrity of the Self • Surviving Systemic Violence • Protecting the Vulnerable Self • Connection with Others
Supports Can Help Or Hinder	• Cutting Contact – Vulnerable Alone • Reciprocal Care • Surviving a Corrosive System
Asserting self – "I know what I want"	• Asserting Agency, Creating Identity • Releasing Shame • Being 'good enough'

Master Theme One – Sense of Self Smashed by the Streets

"It's horrible being homeless. The world is a very hard place" – Kate

This master theme illustrates the many ways in which individuals talked about the external vestiges of their sense of 'self' – material belongings, relationships, public roles and fundamental freedoms were gradually wicked away by circumstances outside of their control. To counteract this, participants discussed being able to preserve an inner sense of self and belonging by forming relationships with peers and services. This master theme encompasses four subthemes: loss of integrity of the self, surviving systemic violence, protecting the vulnerable self and connection with others.

Loss of Integrity of the Self

Participants' narratives suggested that being homeless had a detrimental impact on their ability to look after their basic needs, such as sleep, and accessing healthcare. Kate began to have seizures after sleeping rough, becoming an alcoholic and experiencing multiple physical assaults. She described embarrassment after being caught seeking shelter by sleeping on the bus and missing her stop:

> *"it was embarrassing… that was 'cos the seizures… because I wasn't sleeping… I was losing weight terrible… the worst thing was not sleeping, and on the bus, I'd fall asleep. I'd fall asleep on the bus by accident. The bus driver came and give*

me a shove and said this was the last stop. I was further than I needed to be" – Kate

Kate described a physical toll, saying "losing weight terrible" – being homeless literally causing her to reduce in size. Her physical health also reduced and she was not able to rest, was woken up abruptly and was unable to recoup the loss of health or safety. She described being at the 'last stop', both physically and emotionally, and being forced off with a shove. Kate described trying to seek safety in a place where it was not available – the bus – in part because she had passed the 'last stop' – going beyond the rules for the context she was in.

The influence of rules and how they can quickly impact a person's safety was common in other participants' experiences. Enforcement of arbitrary rules did not make sense to Kelly, who was faced with living in chaotic hostel accommodation:

"I don't think [hostels] look at the vulnerabilities of the person... at [hostel] if you're not back by a certain time they won't let you back in... which is ridiculous... you've got lots of women prostituting themselves... escorting... there's men there... smoking spliffs, and the staff don't say anything. And I just think, what? When did this happen? it's a roof over [your] head but it's not good for people... not for vulnerable people." – Kelly

The enforcement of rules such as curfews did not keep Kelly's hostel accommodation safe; indeed, drug use and petty crime were widespread. Her experience paints a

picture of confusion and incredulity at a system which places vulnerable people in situations where they could be harmed, with the only other option being to sleep on the streets:

> *"They didn't try to find me anywhere to stay that night or nothing they just let me go... and I literally slept in a churchyard at night... there's no aftercare."* - Kelly

Simon described what he had experienced while sleeping rough:

> *"I knew that I had no self-worth and no self-esteem. People used to throw drinks on me piss on me... people used to spit at me... when I was on the doorways and stuff... and that just adds to how shit you feel anyway. It just makes you fucked... your living conditions are reduced to the animal level"* – Simon

A sense of hopelessness and anger comes through in this extract – Simon '*knows'* he has no self-esteem and no self-worth – clearly communicated by the aggression he was exposed to. The abuse and degradation he faced while sleeping rough adds to his sense of hopelessness; if something is *'fucked'*, it suggests it is done with, useless, broken. Simon describes living with limited choices, in *'animal level'* conditions; occupying liminal spaces and facing *'piss'* and *'spit'* from the public. Simon's extract encapsulates the process of erosion of self from a place of safety, protection and

predictability, to animal like conditions; and these conditions gradually become internalised.

Participants talked about the ways they coped with being '*fucked*' while on the streets. Alcohol or drugs were an immediate way to get rid of problems temporarily:

> *"...I was alone again... I started drinking again. The drink takes away the problems but then there they were there the next day. I was drinking all the time and a bit of money that I had I was buying drink..."*- Kelly

Although Kelly knew her problems would still be there, drinking allowed her some relief, even though this used up all of her resources, giving a sense of how urgent a priority this was for her at the time. The urgency communicated here gives a sense of the need to escape -albeit temporarily- from the erosion of personhood. Similarly, Matt used drugs to cope with sleeplessness and anxiety:

> *"... sometimes the only way to get a good kip is to get smashed. I read somewhere that if you don't sleep it can kill you and that really scared me because I never sleep well unless I'm smashed. I've read about the fact you can get psychosis if you don't sleep..."* Matt

Matt described using substances as a way to manage his fear of being killed as a result of not sleeping, giving a sense that he sees his predicament as fatal. Matt has a creeping awareness of how serious mental health problems can get –'*psychosis*'– and sees them as something to be feared. Use of the slang '*fucked*' and '*smashed*' in

this theme reflects the participants' perceptions that they, as human beings, have been destroyed or irreparably altered by their experiences of being homeless.

Surviving Systemic Violence

Many participants described situations where they were removed from places of relative safety. There was an interesting convergence across six participants' description of moving between accommodation:

> *"I was kicked out"* - Simon
>
> *"I was thrown out"* - Kate
>
> *"[I was] kicked out"* - Kayla
>
> *"I was chucked out"* - Jim
>
> *"I was kicked out"* – Dave
>
> *"[we were] ... kicked out"* – Kelly

The use of the slang phrase *'kicked out'* illustrates the participants' perception of removed (rather than moving by choice) from place to place. *'Kicked'* suggests force, while being kicked *'out'* suggests being discarded. This short phrase encapsulates participants' narratives of being cast out from homes, services and support networks, before being left exposed and vulnerable. After having been '*kicked out*', individuals related the ways they were at risk of structural, physical and emotional violence while homeless. Participants who had been '*kicked out'* described a fear of the police and state agencies; a sense that they might be *'stitched up'* and perhaps left more vulnerable as a result of their homeless status:

"I got stopped by the police for no fucking reason. Walking down my friend's road. They asked me if I'd ever been known to the police… then they wanted to know what's in my pockets… I don't want to say it's like being raped, but… it's physical intimidation… then they will stitch you up" – Matt

The striking use of language, likening being stopped by the police to *'rape'* illustrates the expectation of violence and a sense of powerlessness to resist harm from individuals with authority or control. The impact of this description illuminates the sense of violation felt by Matt in this extract. This power imbalance was evident in descriptions of assault from the public; Kate described being verbally and physically assaulted in a public space:

"You got people peeing on you, got people making fun of you… I got attacked in town. Got a boot to the head." – Kate

Here, the slang phrase '*kicked out'* is enacted in this description of physical assault. Like Simon, Kate reported being urinated on and humiliated in a public space. These episodes of violence were not confined to the streets, but also happened to Simon when he sought out safety:

"… they were supposed to be taking care of us but instead they knocked the fuck out of us… it's not a nice environment… just constantly fighting. People

were scalded with sugar and water, there are worse things out there... slashings there..." - Simon

The intensity of the language used here communicates how desperate this situation felt to Simon at the time. There is a sense of betrayal; Simon expected someone (or anyone) to provide care, when he first experienced homelessness as a teenager, but instead witnessed and experienced violence, with the threat of worse things *'out there'*, hinting at the lack of safety in the outside world.

Protecting the Vulnerable Self

Participants talked about the strategies they employed to cope with violent, threatening experiences while homeless. They were in the difficult position of needing to protect themselves from physical harm as well as deal with exclusion from relative safety when '*kicked out*', despite feeling unable to trust the police or traditional forms of safety for fear of being picked on. Liam talked about his need to become defensive about his belongings, or else people would *'take everything'*:

"It taught me... just say no. Just say no because people will take and take... that was one of the biggest things I learned..." – Liam

Liam went on to describe what happened when he started to say 'no' – he quickly felt isolated and like he didn't fit in:

"...it felt odd. Like I was the odd one out. I didn't know where I fit it in. I didn't fit in with people in prison I didn't fit in with people outside I didn't really fit in with people off the streets didn't really fit in with anyone." – Liam

Liam describes feeling like the 'odd one out'. The idea of being 'out' emerges; either outdoors or, in this example, relationally on the 'outside' from others when he left prison. The risk of drawing boundaries and asserting oneself to keep safe is that you could be on the 'outside'; a risky, dangerous place to be alone. Protecting some aspects of the self sometimes meant exposing oneself to other dangers. Kayla described staying in temporary overnight shelter, sharing a space with lots of other people and feeling scared:

"I was getting sick of it... it was scary. The staff were fantastic but it was the people that were sleeping there as well... it was scary I think for a woman, being in a circumstances like that. I've never felt so vulnerable in my life... I've been in prison and I was ok. I was in a hostel I was alright... but being there it was scary... inside I was dying. It was killing me. I'd curl up into a ball and cry. I'd say please God get me out of here. I needed help but I didn't know what help I could get. " - Kayla

Here Kayla clearly described fear, vulnerability and exposure. The plea to God feels like a desperate act, literally begging for escape. Despite the staff being *'fantastic'*, the accommodation felt scary and overwhelming for her. The intensity of being *'sick of it'* made her feel like she was dying; the accommodation was worse than prison,

worse than a hostel. 'Curling up into a ball' is a protective position taken by someone who feels completely vulnerable and helpless; it evokes an image of the 'freeze' response to overwhelming situations. Once she found secure accommodation, Kayla described a situation where she had to cut ties with a group of friends who stole from her after moving into her new flat:

> *"[I was told]... don't tell them [friends] that you've got a flat... but I didn't listen to him because I was one of the first of all the people... to get a flat... they were my friends so I did invite them back but that was a learning curve for me... It was small things at first... going missing. It taught me a valuable lesson that you have to be careful about who you let into your life."* – Kayla

Kayla was warned that inviting others to her flat could cause problems – suggesting this has happened to others. Kayla described this as a *'learning curve'* – she learned to be careful about who she trusts and who she *'let's in'*. Kayla learned to draw boundaries with other people to protect the '*small things'* and the bigger things in her life.

Connection with Others

Participants described being *'outside'* – physically and relationally. When talking about how they got through being '*outside'* or avoiding danger, they often talked about the connections they were able to build with other people. Simon contrasted the connection he observed in prison with the lack of connection out of jail:

"People have it all in jail… they have community they have friends… they love the banter, they love all the buying and selling… it becomes their family and their way of life… so, when they come out… they're grieving for that. They're at a loss." - Simon

Simon describes *'people having it all'* while being in jail, perhaps positioning himself as an expert by experience. The idea that jail is somewhere a person could 'have it all' – an observation usually reserved for footballers or millionaires, is an interesting observation from Simon, giving some insight into his perception of what 'all' means. This is in stark contrast to the loss of material and relational safety described when sleeping rough. *'All'* is described here as community, friends, banter, buying and selling; that is, a sense of connection, commonality, humour and reciprocal care. Simon describes this connection as an adopted family. Leaving jail is a bereavement, a loss of *'family'*.

To cope with loss and repeated experiences of being '*kicked out'* from various services and agencies, individuals strove to find ways to meet others in similar situations, forge friendships and alliances, and meet their needs as social beings. Matt succinctly described this as needing human contact. Perhaps the use of '*someone'* here could mean 'anyone':

"…what I really want to do is just to be with someone… like this house is a shithole but it's just having the human contact." - Matt

Kate previously described the risk present on the streets following repeated assaults. Her solution was to *'walk all night'* and talk to strangers:

> *"I never went to one place for tea or anything like other people did. I never went anywhere to sleep. I would just go back and forward from different places. Walk into town, out of town. I'd walk up to [nightclub], at [street name], talk to all the people going out. Talk to the bouncers all night until the morning. I just keep walking. It was tiring."* – Kate

Kate describes doing something on her own, not being like the *'others'*, but keeping herself safe by walking and talking. These connecting conversations with people working and on nights out occupied her time but also gave her a sense of connection to the real world and a distraction from the world she was currently inhabiting.

Master theme Two – Support Can Help or Hinder

"Anyone can drink, anyone can do drugs... it's the emotional support that people need to identify what is going wrong." – Kelly

This theme speaks to the experiences participants had while seeking help and support. The theme illustrates the barriers and hurdles participants faced when seeking support and reflects that some aspects of 'support' do not always equal safety. As Kelly describes above, emotional support was an essential factor in her

recovery, a thread found throughout participants' narratives. This master theme encompasses three subthemes: Cutting Contact - Vulnerable Alone, Reciprocal Care and Surviving a Corrosive System.

Cutting Contact - Vulnerable Alone

Participants described the dilemma of leaving old friendships behind and trying to extricate their support network of friends and professionals once they were able to reduce or stop using drugs. Dave described feeling isolated once he had chosen to get clean and leave his old friends behind:

> "*You have to be so careful with who you mix with... there could be some people who would be constantly talking about scoring... it's like that saying: 'if you sit in the barbershop long enough, you'll get your hair cut'. So, the end result is isolation once you're trying to get clean... it's very isolating."* - Dave

The phrase "*if you sit in the barbershop long enough...* " occurred in four of the eight interviews. Participants used it to describe a situation where they were surrounded by chaos and drug use as well as barriers to getting support for getting *'clean'*, meaning it was almost inevitable that they succumb to the temptation to use drugs again. The choice to be alone was difficult, both emotionally and practically:

"I've had to cut contact with all my friends… all the people I was friends with. Had to change my phone, change my phone number. [My sponsor] said: "if you sit in the barbershop long enough, you're going to get your hair cut"… but it's been hard. I wish them all the best. I hope they can… get some help" - Kayla.

The use of the word *'change'* illustrates how Kayla had to break real-world connections to her old group of friends and intentionally isolate herself. She corrects her language at the beginning of this extract and this could reflect her changed perspective: these were friends for a time, but not now. Her sponsor introduced the idea that if she didn't do this, it would only be a matter of time before she fell into old patterns of behaviour. Her compassion towards her friends in this example perhaps reflects the compassionate stance she is taking toward herself by actively working toward her recovery.

Participants had to rebuild and reconstitute networks of friendship and support to avoid problems 'spiralling'. This was not an easy choice and required effort on behalf of homeless individuals, to clarify what was needed when removed from their community and their world, beyond material items. Dave explained:

"I think that's how you become entrenched, once you spiral it's harder to get out. Even if you get somewhere to stay, you're in a flat locked in with your own thoughts. … and that's maybe scarier than sleeping on the streets. You're not alone on the street. When you take people out of that, you're taking them out of their community, out of their world." - Dave

The idea of being *'locked in'* illustrates a sense of helplessness, being trapped with something scary, intangible and uncontained. The level of vulnerability is sometimes intolerable. Despite having a basic need – accommodation – met, as Dave describes, some people can end up returning to their communities on the street.

Surviving Corrosive Systems

This theme builds on the earlier theme Erosion of the Self. Participants discussed, once homeless, having to survive in systems which continued to corrode their physical and emotional wellbeing. Participants discussed how the support structures designed to protect could become dehumanising and lead to further problems. Matt described a loss of physical safety when sleeping in a hostel:

> *"Stayed in this horrible place... one of those places where you have to sleep with a knife under your bed... because otherwise... y'know... You weren't safe..."*

> *"... There was a load of us [sleeping rough]... it was pure hell, like a nightmare. You're just trying to get through the night. You think about suicide and stuff... like asking... is it worth living. You feel worthless, so other people think you are worthless."*
>
> - Matt

'One of those places' suggests that the situation Matt describes is common enough to be a 'type' of accommodation. Having to keep a concealed weapon under the bed gives a sense that danger could come at any time and that when a person is at their most vulnerable – sleeping – they are not safe. The only way to ensure safety was to become defended against potential attack. After a period of living like this, Matt described how suicide felt like an option. His experience of others experiencing him as worthless is an interesting insight into how he imagined himself from the perspective of another. His use of 'you' rather than 'I' provides a sense that the experiences he is describing here are emotionally charged; he is distancing himself from the emotional weight of these memories.

Kate shares her experience of being transported from two different hospitals for treatment, without her consent or conscious awareness:

> *"They sectioned me... [put me] in a hospital transport with blacked-out windows... they took me there, and I didn't know where I was. My mind wasn't functioning. Didn't have any form of contact with anyone, didn't know where I was... I was on my own... they wouldn't tell me where I was... they wouldn't pull over so I could have a smoke... it was scary. It's like being passed from pillar to post. I felt really bad... I wanted to finish my life."* - Kate

Kate mentions location three times in this extract, giving a sense of the anxiety she felt at being transported to an unknown place. The blacked-out windows would have prevented her from picking up any cues through the window as to where she was, or

where she was going, as well as appearing quite sinister. The idiom *'from pillar to post'* is used in this extract. The origins of this saying are thought to be from the practice of public punishment, where someone would be tied to a pillar and whipped or locked into a pillory. Here, Kate was locked into transport and taken against her will, while her requests for relief were ignored. The distress from this experience made her feel like life was not worth living, a parallel to Matt's conclusion that he felt worthless.

Support systems like rehab could have a corrosive quality; and there was a risk that this could erode any will people had to change their situation. Simon talked about the importance of his key worker, who helped him traverse the barriers to recovery:

> *"You got a lot of people who go to [addiction service] and they're saying to them you'd [need to] come here with clean urine three times... and then we'll put you forward for the [recovery service]... and you're like fucking hell how the fuck am I supposed to do that? if I could come in here with three negative urines... I wouldn't be standing here asking for a methadone script! [my key worker] got me into an independent rehab straight away, without me having to jump through all these fucking hoops."* - Simon

Frustration, anger and desperation come across in this extract. 'Hoop' jumping was a common way of describing accessing support for participants. Here, Simon describes how he was able to avoid 'hoops' with the help of a key worker. The analogy of hoop-jumping evokes imagery of having to perform and, in this case, of help or

support being contingent on the ability to perform for the person or system that holds the hoops.

Some systems that people engaged with gradually eroded a sense of agency and hope by enforcing arbitrary rules and 'hoops' to access support. However, this was not always the case. Dave described a process of finally acknowledging that his health was in grave danger. Despite still being addicted to heroin, he got himself into a hospital:

> *"I didn't want to die. I'd always wanted to get off drugs. At the time I was looking at going to jail for two years… so I thought that was the way to get clean… but they ended up keeping me in hospital for weeks. Probably the first time in my life, I felt safe. The nurses were amazing. My friend brought me weed in, the nurses knew I had a spliff, but they didn't say anything. Because I wasn't using heroin. They looked after me properly."* – Dave.

The beginning of this extract is powerful; Dave asserts that he wants to stay alive. To do this, he sought out help at a hospital, with the other option for shelter being jail. Dave describes the care he had as '*amazing'* due to the safety that came along with the medical help he received. It is meaningful that this was the *'first'* time Dave felt safe. Here, *'proper'* care meant supervising Dave – the nurses knew when he was breaking the rules, but they flexibly applied their power to keep him in hospital so he could get better. From Dave's extract, it seems that the role that staff have in an individual's recovery cannot be overestimated.

Even when a person had successfully jumped through hoops and received support, the reality that systems themselves are at risk was anxiety-provoking. Matt had found day services useful, but his worry that the centre he attended might lose funding hung over him:

> *"How I look after myself now? I just come here. Take advantage of all the services that are here... you never know when that funding... is gonna go. I just hope that it doesn't because I dunno where I'll be then. I'm scared because I won't have a clue what to do."* - Matt

Matt described a sense of fear that his support system will '*go'* as well as a sense of helplessness – *'clueless'* – suggesting he feels ill-equipped to begin searching for support all over again.

Reciprocal Care

Once participants had been able to successfully navigate the initial isolation brought about by the journey toward *'getting clean'* and surviving corrosive systems, many sought ways to *'give back'* to others, wanting to help people in similar situations to their own.

> *"it's caring for other people... and it's nice for them to have somebody to talk to you as well. There's nothing worse than being at home and having no one to*

talk to. It's giving back… back to other people who need it. While making something of my life. I like being on the ground in the midst of it all!" - Kelly

Kelly described a sense of wanting to *'make something'* of herself, suggesting that by helping others, she is also helping herself. Her description of being *'on the ground'* is an interesting parallel to people's experiences of sleeping rough. Here, Kelly is keen to return to the streets but this time as a helper, rather than someone needing help. This sentiment is echoed in other participants' experiences. While homeless and battling addiction, Kayla tried to protect others who were staying in the same hostel as her:

"This young lad… he had been made homeless… I used to stay up all night talking to him. He said that if it wasn't for me, he wouldn't have come back every night. It helped talking to one another. Talking"- Kayla

Here Kayla described being a helper, even while she was in a precarious situation herself. She sympathised with his situation and it helped to talk, perhaps that help was not as one sided as Kayla initially described? Confirming the importance of connection, Kayla provided a connection for this lad by talking, ensuring he came back to the temporary accommodation and was safe at night. Over time, experiences of care became internalised and began to express as care for oneself and eventually, a sense of purpose and agency:

"*I used to think that you just worked to make money you just work to live… but I realised having something just to get up for in the morning is still a good thing to have… whether that volunteering or college or whatever… you still need that. That's the thing that can keep me more stable in my life. Like a core purpose… it doesn't have to be paid work it just has to be something that does that.*" - Dave

Dave describes a process in which he has moved from a fixed idea about what he needs in his life (in this case, paid employment) to considering the purpose and values underlying his day to day life, recognising that acting on those values brings about stability. This is an incredibly protective factor in his life. He describes it as a 'core' purpose, suggesting that it is central to the rest of his recovery and stability.

Master Theme Three – Asserting the Self – 'I Know What I Need'.

" [it is] not about drawing to perfection… to someone else my work might look like shit, but to me, it's meant so much." - Kayla.

This theme develops the previous subtheme of reciprocating care. Here, participants described how they began to recognise and meet their own needs. This theme captures how participants were able to assert their agency, build a sense of self-worth and begin to create a 'good enough life' for themselves. Participants found ways of doing this by using the resources around them and were able to pick and choose what they got involved with. As Kayla described above, she had never painted before but found a creative outlet that enabled her to express herself. This

master theme encompasses three subthemes: Asserting Agency, Creating Identity, Releasing Shame, and Being Good Enough.

Asserting Agency, Creating Identity

Education provided a platform for the development of self-esteem and identity for many participants. Jim was able to research the effects of childhood trauma and abuse, which gave him a sense of who he was and a new perspective on his early childhood experiences:

> *"I've done some research... I've read books on child trauma and what happens to your brain... emotionally, psychologically... biologically. And it's just like, holy shit, this is me. It makes it a lot easier to say that it wasn't my fault now, now that I understand those experiences... I realise... I had loads of bad thinking, but it's weird because it also makes me who I am."* – Jim

The shock Jim expressed here at seeing similar experiences documented in a book "*holy shit!... This is me*" captures the relief he felt to realise he was not alone, and the release of guilt at acknowledging that he was not at fault for what happened to him. This extract captures the emergence of a new identity, combining historical experiences and new information, and where Jim is making tentative steps towards integrating old and new. Acquiring new information, knowledge and skills was important to many participants. Kate described a newfound sense of achievement, having completed a few courses arranged through her local women's centre:

> *"I've done the [name] program, I've done the creative writing courses, I've done a course at the uni… people find it really hard to get back into education, but I say if you don't ask you don't get"* - Kate

This theme illustrates that participants become able to identify their needs, or what has been missing. The common phrase "*If you don't ask, you don't get*" suggests Kate's recognition that she can now assert her individual needs and ask for what has been missing. Kelly shared similar experiences and proudly displayed her folder of achievements and certificates. She described how completing her qualifications encouraged her to pursue further education:

> *"It was once… once I believed that I wasn't thick… when you grow up your whole life thinking you're thick… I did one thing and was able to take it all in, did my English course, gone to college and was like… "oh my god I can actually do this! I can actually educate myself"… that's made me strive even more."* – Kelly

Kelly shed a sense that she was not able or worthy to pursue the things she wanted and found herself gaining momentum with each small success. Similar to Jim's extract above, when Kelly says "*I can do this…. myself*", a sense of agency and ability emerges as a result of taking on a college course, creating a sense of independence. This sense develops from a place of relative safety, away from the erosion of self and safety on the street.

Releasing Shame

Once participants began to gain a practical handle on their self-development and personal agency, they felt more comfortable challenging some of the narratives that surrounded them and releasing the shame they carried as part of those narratives. For Kayla, telling people about her problems with addiction allowed her to release a sense of shame she had about '*doing the wrong things*'. She talked about hiding '*behind a façade*':

> *"I was always so worried... [that I was] doing the wrong things... they said I didn't look like a typical drug user, which I found really judgemental. The drugs I used never showed up on tests... when I really needed help, because of my image... I was hiding... it was all fake, behind a façade... because I'd had a wash, because I have clean clothes... doesn't mean I'm not a drug user. I managed to get away with it most of my life... I was still functioning really well but inside I wasn't... and nobody could see that... they could just see the outer shell. "* – Kayla

Judgemental attitudes and bias were common hurdles for participants to overcome. Kayla was able to reconcile her *'fake'* persona and the assumptions people made about her to realise that being able to '*get away with it*' was part of the problem; it wasn't helpful, while being honest about her drug use was. She stopped hiding

behind the outer shell and adopted a more authentic stance. Simon described being able to *do 'normal stuff'* he couldn't do before:

> *"Being able to buy clothes rather than buy drugs. I was able to go out at the weekend by myself a new pair of trainers... just the normal stuff. It sounds mad... but I went to steak house on [street name] the other night spent 15 quid on a steak and had a laugh... just me and my friend. But I used to walk past there and dream about going in there. It's sad isn't it?"* - Simon

Simon had difficulty reconciling the normality of his life now with how he felt when he was sleeping rough. By doing 'normal stuff', he accomplished a dream. However, this achievement is tinged by sadness as a result of gaining a new perspective on his old situation. Dave described a similar new perspective on his experiences:

> *"... [wouldn't be here] without the support I've got... because it's all in my head and when you speak it out loud you realise how shit your childhood was (laughing). Makes you realise that stuff was out of your control. I'm classed as what you would call a success story really... I was an entrenched rough sleeper... and I've got here where I'm clean... I used to pray to God that this would happen. And I don't really believe in God either (laughing)."* – Dave

Dave's narrative is now one of success rather than failure. Part of that transformation has included sharing his story and realising that he was vulnerable and helpless to change some of the things that happened to him. Like Simon realising his dream,

Dave described this as a fulfilment of his praying – and perhaps that this is an outcome that, at one point, he couldn't believe would happen. Dave described a transition from hopelessness to being hopeful. Participants described experiences in this theme of recognising defences and reaching a point where it felt safe to step into authenticity and vulnerability to begin a new period of their lives.

Being 'Good Enough'

Participants who had successfully navigated treatment and recovery turned their attention toward the future. This partially involved realising that ordinary, mundane things could bring happiness and fulfilment, and developing ties to people and places in the local community to help protect against relapse. Simon reflected on his journey from sleeping rough to where he is now:

> *"I get a bit sad when I walk through town when I think where I was. I know what it feels like to be out there, to be lost and to be broken and angry and frustrated. People need to reach out and ask... what their hopes are. Why aren't you in a hostel? Where's your parents? Ask them why are they here, and what do you need?"* - Simon

Simon recounts the questions he feels would have helped him if someone had asked. The question '*what do you need*?' feels central here. So many participants described being 'done to' – forced through hoops to access support or asked to follow arbitrary rules for help. Simon's questions are centred around hope, from the perspective of

someone who has 'lived it' and suggest a push for empowerment by asking for needs rather than assuming what is needed.

> *"...I'm not really an artist, I'm not really into painting... I want to paint I see artists being quite personal... it's not about drawing to perfection... that's me... when I've done some my work and it's been put forward... and to someone else my painting might look like a piece of shit but to me it meant so much. When I did that and it was put forward, they say that there is an exhibition... and they put my face forward and had it in this exhibition and it was quite an achievement."* – Kayla

Kayla's extract provides a succinct illustration of the process of understanding 'good enough'. She tried an activity as a means to an end – self-expression – and accepted that while it isn't perfect, it means a lot to her and provides a vehicle for a sense of achievement and pride. There is also a sense of perspective; acknowledging that to an outsider it might *'not look like much',* but the value the piece has for her is huge.

Earlier themes captured how some services alternated between providing strict support, full of rules, or chaos, with little safety or protection. Kelly described this as the *'bubble wrap'*: being caught between a system of control and a system of chaos. She felt that this could be improved, and her strategy for that was to accept the grey areas when rules need to be flexed and applied carefully, and to use the expertise of people with lived experience to show the way:

> *“they [service commissioners] don’t seem to acknowledge that people have real issues, they have to deal with the real issues. If you’re stuck in that bubble wrap all the time, how are you going to move on?... I don't think [service users] given or shown that way... showing that it's possible... make them understand a bit more... having people with lived experience to show them.”* - Kelly

Kelly’s extract sums up a process where participants were able, over time and with support, to identify their own needs, seek sources of support and eventually, actualise their motivation to help others in a similar situation. As Kelly describes above, some of that motivation can be channelled into naming and tackling the ‘real issues’ at a systemic level.

Findings: Focus Groups

The aim of the focus groups was to get a professional perspective on what it's like to provide services for homeless people. The focus groups were analysed using thematic analysis. Three themes were identified, as shown in the table below (Table 5). A list of themes and example supporting quotes can be found in Appendix I.

Table 6: Focus Group Themes

Theme	Subthemes
Professional 'Hoops'	• Working within complex systems • Invisible Labour • Sharing and Caring... (and Targets)
Barriers to 'Good Enough' Services	• Systemic barriers to 'good enough' • Cycles of rejection
Caring within Complexity	• Challenging a Culture of 'Not listening' • Building Bridges

Theme One: Professional 'Hoops'

All focus group participants discussed the difficulties they encountered when doing their jobs and were able to name the barriers and challenges they had experienced as professionals. They identified two layers of their role, which are described within this

theme: a layer of person-centred care, and then another 'invisible' layer involving bureaucracy, targets, and professional 'hoops' to jump through. This theme encompasses three subthemes: Working Within Complex Systems, Invisible Labour, Sharing and Caring... (and Targets).

Working Within Complex Systems

Participants were first asked what they as professionals, working within homelessness services, perceived to be the barriers to doing their work. Many participants discussed how challenging it was for them personally to overcome the complexities of services and state provision. They recognised that for some of their service users, it was easy to 'fall through the cracks' because of the ways services struggled to integrate, communicate and work together:

> *"The services are not designed in a way that makes them accessible to people, particularly people that fall between or don't quite meet criteria."*

One of those 'cracks' participants identified was the legal and diagnostic 'blurred lines' around capacity and consent:

> *What we sometimes deem as health professionals... that someone doesn't have capacity... but then they go up to the ward and the staff on ward deem them to have capacity. It's like... actually, we know the person and a relative knows them, they're not their normal selves."*

Professionals also talked about how hard it was to get access to information about a service user, which often meant having to repeat work or ask the service user to repeat themselves at each service visit:

“They won’t share any data with us… [in the voluntary sector]… we need to get information to pass it on to the ward, but because we're bound by confidentiality and data protection… even with consent forms and everything."

Quantifying the work done to care for people was difficult, especially for people whose jobs involved preventative action, such as preventing admissions to A&E:

“It’s so difficult… it's almost like you're working backwards. How many A&E admittances have we prevented? … there's no way to record that."

Recording outcomes and the inherent challenges of recording a ‘successful’ outcome were discussed. At times, the goals of management or funders would conflict with the desired outcomes for the service users:

"In whose eyes is it successful? For the provider or for the service user?

This statement resonated with all focus group participants – the challenge of pleasing funders, commissioners or managers with pleasing outcome figures versus

helping the individuals who they are employed to help was a conflict that was discussed throughout both focus groups. This is covered in more depth later in this theme.

Invisible Labour

Focus group participants discussed how demanding their work is, how it required a number of intangible qualities, and how emotionally invested it required them to be. They described this as the '*give a shit'* factor, which they felt made a real difference to the quality of care their clients received:

"So, what are the personal qualities? Authenticity, integrity, commitment… I think it's just called the 'give a shit' factor."

Participants discussed conflicting goals and demands in their work and how they were able to balance them in their minds. They also highlighted trying to keep the needs and feelings of their clients at heart. They wanted more people coming into the sector who reflected those values:

"I came into this job because I cared. I cared, and this is my humanity. But you've got to have the right people in the job, the people who say, 'let's sit down and talk about it'."

Focus group participants talked about needing to be 'hardcore' if they wanted to make a difference, rather than being in it for the wage:

"We've got the really hardcore people who want to be in the job and who want to make a difference. Rather than "That's a good wage, that"."

Working within the sector required building up a layer of protection and compartmentalising the working day. In part this was due to the challenges and sometimes the tragedies professionals witnessed when doing their work. A participant described this as 'armour', which is suggestive of a notion of going into battle each day:

"You do build up a sort of layer of armour, you know, you do tend to put things into boxes and put things away when you're not working with them, because you have to when you're working in that environment."

Sharing and Caring... (and Targets)

Focus group participants discussed the ways they had been challenged in their roles, but also the ways in which they had individually tried to meet the demands of their individual cases and systemic pressures on them as professionals. They expressed their sense of passion for their work, despite facing multiple challenges and barriers. A strong theme was how staff cared for the service users coming through their

services, employing creative and thoughtful ways to make services more pleasant for the individual, while meeting the need for a positive 'outcome':

"We've tried to match people up… in terms of compatibility… it's about having family here, and that sort of environment, that struck a chord a bit. How you get a better outcome."

'Outcome' in the above quote seems to capture the need to at once have a positive outcome for the service and for the individual – a tricky mix to achieve. The challenge of balancing the emotional work involved (caring for other human beings) and working within an outcome driven service (collecting data) was a persistent topic of the focus group discussions:

"So the data that we collect is "A&E admission, date and time etc."… I mean, my day today and yesterday, I couldn't collect data on it because it's spending time with that person and I've listened to them cry, and all the rest of it. There's no data that can be collected for that."

Advocacy allowed professionals to employ their skills and their knowledge of services to support and advocate for the wellbeing of their clients, while also sharing the experience of the barriers to services for their clients:

"…when he [client] eventually did go in with somebody [advocate] and have somebody sit in on the appointment, and kind of put his point across, and ensured

that he was heard, about what he was saying, and persuade the GP to try it and see, and it has really worked for him. But it is that thing about having a certain history that you voice or your… knowledge about yourself and the circumstances of your own health issues, is very often, just not heard. You're seen as the addiction issue, rather than the person who knows their health needs."

The issue of 'not being heard' was reflected in a later extract from another professional and bookends the example above with an example of challenging the system that often does not see or does not listen:

"I assisted a service user to write a complaint to a service recently because every time they went in they wanted to talk about that person's partner… they kept wanting to focus on the partner… he just wanted to change his key worker, and really what should have happened… he should have said 'would you just listen to me?'"

Here, the client's voice was lost amidst conflicting service demands; the client's partner was the focus of the individual's appointment at a GP practice instead of the individual present at the appointment. The professional in this extract shared the frustration and anger at not being listened to on behalf of their client, echoing the client's frustration and anger: '*would you just listen to me?*'. In a similar way, the needs of the professionals in the focus groups were also lost amidst an array of pressures and limitations on services, which the researcher has tried to capture in this theme.

Theme Two: Barriers to ‘Good Enough’ Services

This theme reflected the systemic and practical obstacles that professionals recognised as systemic hurdles for services to overcome to do a ‘good enough' job. This theme encompasses two subthemes: Systemic Barriers To ‘Good Enough’ and Cycles of Rejection.

Systemic Barriers to ‘Good Enough’

This theme is concerned with what it meant for professionals to be aware of the systemic gaps in service provision while feeling disempowered to do anything about those gaps as a lone employee. One participant referred to the element of luck involved in getting an effective service:

> *“If they’re lucky, they might get referred on to another service. But there will probably be a gap where they aren’t getting anything. There isn’t that continuity for people at all.”*

Service users had further difficulty if they presented to services with multiple diagnoses, having to navigate other services’ restrictions on what they could access

(for example, some services have diagnostic thresholds which are gatekeepers of access) depending on that diagnosis:

> *"Getting a service for someone with a dual diagnosis is damn near impossible."*

Participants sometimes referred service users to unsafe accommodation despite knowing it may be problematic to their mental health because there are no other options other than sleeping rough. They were required to make difficult decisions based on limited options:

> *“They don’t feel safe, even in hostel accommodation. They are in the ‘madness’ as they call it. It’s all around them, and there are other people accessing drugs… a lot of people have not wanted to go into hostels for that reason… they've been really scared of going in."*

The sense of helplessness communicated in the extract above is reflected again in a discussion of why services are like this at all. One participant observed that both ‘good’ and ‘bad’ services are designed that way:

> *“You create bad services. The whole drive on prevention, the ‘no second night out’ approach… the focus was on quickness… it isolated hard to reach people even further. I think it made the situation a lot worse."*

This sense of the systemic being ‘out there’ and divorced from the reality of their day-to-day work was reflected in a discussion about how the political climate influenced their work via targets or outcomes, but it was never the other way round. There were times when local politics drove service provision in a particular way:

> *"It's always a political agenda… like, a newspaper will say, ‘we have this problem with homelessness', and then we'll get a call. It is politically driven."*

However, this political drive at a commissioning level was sometimes useful, and enabled professionals to petition for commissioners to ‘take a chance’ on projects or services that might be seen as risky:

> *“Some commissioners have been really good… some have been really forward-thinking. Some have listened to on the ground services, saying, what does good look like for you?”*

Participants acknowledged that they were from different organisations, serving the same client group, and at times there was a competition for funding or commissioning bids, putting a strain on resources and creating an uneasy sense of competitiveness between organisations:

> *"We have a big group of organisations working together… but who are actually competing with one another for bids. That makes for an uncomfortable fit. It's not ideal I have to say… it's problematic at times."*

The ‘problematic’ aspects of the challenges described here are similar to some of the personal, individual challenges described in earlier themes, but what is markedly different is how participants located the source of the challenge ‘out there’; in the political or commissioning sphere and felt quite disempowered to challenge the ‘system’, relying instead on ‘luck’ or sheer chance.

Cycles of Rejection

The conversation moved to professionals’ perception of a typical service user’s perception of services and how people deemed ‘hard to reach' are made that way after having unsuccessful attempts at outreach in the past:

> *"Hard to reach people are the ones who have lost trust in services… you have to be able to get past that barrier where they've been let down by services before and don't see any immediate positive outcome from gaining treatment."*

Another focus group participant continued:

> *"We keep repeating that cycle over and over again with already traumatised people… our systems are harming because we can't get our act together with funding."*

Participants also connected the previously discussed topics of trying to offer preventative services but there being 'gaps' in provision. These gaps could be expensive and counterproductive to someone getting well. One participant gave an example of where services had worked hard to look after someone's health, housing and benefits, but failed to provide options for social support:

> *"There are people I can think of, and the amount of resources that have went into them is massive… thousands of pounds. A lot of it is because they're lonely. So, they'll present to A&E because they've got no one to talk to. 'I'm bored, I'll go and talk to the nurses' – and then they get aggressive and get chucked out, but then present again."*

Participants discussed why this repetition occurs, and why themes in experiences of homelessness seem to be so persistent. One participant talked about how hard it was to have constant temporary relationships with service users, only for them to be referred on just when their working relationship had developed:

> *"If you have been working with someone so-called 'hard to reach', have built up trust with them, by the time you've done that, it's almost time for them to be referred on to somewhere else."*

Like some of the examples within homeless individuals' experiences, professionals also felt a sense of temporary, tenuous connections to their clients, made more difficult (or perhaps facilitated by) the practical challenges discussed in an earlier

theme, like barriers to communication and navigating practical, legal and systemic barriers to continuity and consistency of care.

Theme Three: Caring for Complexity

Professionals discussed practical and systemic challenges, but also discussed the ways in which they were able to push back against these challenges to provide care, despite working within a complex system, for individuals who can present with 'complex needs'. In the same way people could 'fall through the cracks', professionals worked really hard to find 'cracks' in the other direction: moving people through these narrow avenues toward 'good enough' care, safety and stability. This theme encompasses two subthemes: Challenging a Culture of 'Not Listening' and Building Bridges.

Challenging a Culture of 'Not Listening'

Professionals challenged the stigma and prejudice their clients faced, named this as a source of inequality and a reason why some of their clients do not always have good experiences of services. In this extract, a participant describes some of the difficulties that clients face when seeking medical treatment:

“Some of the doctors… are absolutely, really clued up…. It’s a sort of pot luck really. But I think in many ways… because they’re seeing it all the time, they tend to be less willing to listen in some ways to what people are saying to them, as individuals, as individual patients who know their own circumstances, and their own health better than anybody, they’re less willing to listen.”

Some participants felt that issues surrounding homelessness were persistent because the service users themselves were not deemed worthy of support by the general public:

“Within society, they’re not attractive… not attractive for funding and support and resources… people read articles … and there's this perception that people have chosen this way of life, and that people choose addiction and that it's their own fault."

Participants suggested that an antidote to this perception, which they saw as being internalised by people experiencing homelessness, was to ask questions and facilitate choices, even when resources were low:

“looking at… what is it you want? What is it that's stopped you doing that in the past? What would help you access that? And that works really well because people then feel invested in, and they feel invested in the plan as well."

In being ‘invested’ in, both as an individual and in a shared plan for their own care, staff could facilitate service users’ vision for a ‘good enough’ life:

> *“Even if it’s just, ‘I see human beings three times a week', and it comes to that, through their eyes really, what a good life looks like"*

This subtheme echoes a sentiment from an earlier theme: “in whose eyes is it a good outcome?” Similarly here, the expectations or biases that can cloud some professionals’ outlook on working with individuals experiencing homelessness is challenged by 1) listening and trusting what the individual reports as their lived experience as well as their needs and 2) accepting that ‘good enough’ might look very different from the service user’s perspective versus the perspective of the service itself.

Building Bridges

This subtheme speaks to the ways professionals, given the demands and limitations of the role they are in and the systemic barriers facing both them and their clients, were able to overcome these limitations and barriers, build links between services, build rapport with service users and facilitate space for positive change. The metaphor of ‘bridging’ the gaps described in previous themes is used; highlighting the importance of accessibility, choice and personal agency. In this example, a participant discussed the ways they had commissioned support for an individual based on their needs:

"It's very much looking at what people want, what the barriers are, how we can overcome them. We do a lot of that, providing transport, looking at times of days that are good for people. If people aren't good in groups… we can commission things and take things to people on a one-to-one basis if necessary. That really works."

The importance of environment was highlighted as well as the context in which individuals can seek support and just 'be' themselves:

"[the homeless hub] a place where they [homeless people] could go… and access support and just be."

The idea of accessibility being important extended to places where support was located; being easy to walk to and aesthetically non-threatening. Another participant recognised the material qualities which made the homeless hub a focal point within the local support landscape:

"[on the supportive context of the hub] They recognise it as easy to get to, it's central. It's small, it's comfortable, it's a little bit shabby. It doesn't feel scary to access, and we find that that really helps"

Like the importance of access in the extract above, the role of choice and facilitating personal agency was highlighted in this next extract, facilitating a choice (or freedom to choose) of priorities rather than assuming what's important for individuals:

> *"It's choice isn't it? I mean, the people that we work with, whether we want them to prioritise their health, their housing, their wellbeing, if they've got capacity to choose not to, I think, something that I'm very conscious that we do is that we assume that people should prioritise their health"*

Focusing on the present rather than repeating the past was important for professionals in recognising service users' needs. Basing treatment and support on current interests and combining that information with advocacy and choice was crucial:

> *"Stop asking them to repeat stories, and start asking, well what are your interests? What do you like to do? Can we broker those opportunities for you rather than… Go and engage with housing. Go and engage with drugs [service]. Go and engage with health [service]. Because, they might not want to. We have a choice about what we do. If I don't want to go to the dentist, I won't go."*

This participant summarised the reciprocal relationship between capacity and agency:

"Our capacity and agency are two sides of the same coin. You have to have both to make a decision. You have to have the ability to do it, and not be restricted from doing it."

Participants were able to identify the gaps within and between service provision and support, as well as identifying where some of those discrepancies could be remedied through better communication, a person-centred approach, and within this theme, opening up the opportunities for choice with adequate resources in tandem with choice and personal agency.

Discussion

"We live through the stories told by others and by ourselves" – Murray (2003, p.95)

The aim of this study was to gain a qualitative understanding of the experience of support-seeking for people who have been homeless and had difficulties with drug or alcohol addiction. An interpretive phenomenological analysis of eight transcripts revealed three interrelated master themes: *'Sense of self smashed by the streets', 'Support That Can Help or Hinder' And 'Asserting Self: "I Know What I Need."'* To obtain a broader picture of seeking support, it was useful to get an insider perspective on the experiences of professionals who provide support for homeless people and the challenges they face. Two focus groups with professionals revealed three main themes: '*Professional Hoops*', '*Barriers To 'Good Enough' Services'* and '*Caring for Complexity*'.

Descriptions of support-seeking experiences from the participants and professionals in this study reflected the combined impact of a lack of material resources, relational deprivation and the potential for iatrogenic harm caused by structures designed to support individuals and professionals alike. The sense of rejection and worthlessness embodied by participants who had been homeless was often in direct response to structural violence toward them. The frequent appearance of variations of the phrase "*kicked out*" from homeless participants gives some insight into the repetitive nature of rejection from sources of support. This rejection extended from experiencing intimidation and violence from other people to interactions suggesting they are perceived as 'less than' by police, healthcare staff and the general public. Participants discussed the negative impact structural violence had on them, eroding their sense of identity. Over time, confined between the difficulties of sleeping rough or in hostel accommodation, participants experienced mixed responses when seeking help; Matt related feeling that the police and private security targeted him unfairly as a result of his homeless status. Kelly described examples where a private security firm violently removed one of her friends from his stopping place. Dave described how medical staff bent the rules for him slightly, which was instrumental in his process of personal recovery.

Professionals in the focus groups acknowledged the ways in which they are sometimes forced to 'reject', given the limitations and constraints of their roles and the resources available to them. Many professionals acknowledged that hostels and temporary accommodation were unsuitable for the vast majority of service users,

and could, in fact, cause harm, a finding reflected in the literature (May, Cloke, & Johnsen, (2006); Thorpe, 2008). A lack of open communication between support organisations coupled with the pressure of competing for material resources and funding further complicated cross-sector working relationships and successful implementation of interventions for homeless individuals, as other researchers have found (Mackie, Johnsen, & Wood, 2017; Van der Vegt & Bunderson, 2005).

Interview participants discussed how they felt rejected not just by individuals and some agencies, but by society via implicit narratives embedded in culture. In the media, ‘poverty porn' (Law & Mooney, 2011), a voyeuristic branch of reality TV focused on people in financial difficulty, has furthered the perception that people are undeserving of support if they are not employed, an impression indirectly supported by neoliberal attitudes toward health and social care (Mansted, 2018). Legislative measures, such as anti-social behaviour orders (ASBOs), exclude homeless people from public spaces (Atkinson, 2003). The built environment can be redesigned using ‘defensive architecture' (Andreou, 2014) to reject homeless people from stopping places, forcing them to live in an endless liminal environment (Cutler, 2005). Local authority responses to homelessness can range from punitive and oppressive to ‘poverty management' (DeVertuil, 2006). These approaches incarcerate or displace homeless people from towns and city centres to deliver ‘clean streets' for local business and affluent people (Cloke, May, & Johnsen, 2010). This displacement leaves only marginal spaces for homeless people to exist, creating a situation where vulnerable people are exposed to a variety of ‘care and control’ measures from statutory organisations, shelters or hostels that enforce a strict ‘code of conduct’

(Cloke et al., 2010) as well as a set of rigid expectations for how homeless people should behave and live.

Both participants with lived experience and professionals described a tenuous relationship between receiving and providing care. People referred to the homeless hub as a 'sanctuary' and a 'safe space'. By building on the strengths of these 'spaces of care' (Johnsen, Cloke, & May, 2005), professionals were able to create a "place to be and belong" for individuals, but this was temporary and based on limited access to funding and appropriate resources. Organisations that have to compete for resources and the trust of service users (Milbourne, 2009) can end up unconsciously promoting a politicised version of care which encourages a type of 'professionalism', including neoliberal ideals of wellbeing, rather than a user-led, 'voluntary attitude' toward support (Cloke et al., 2010) This was reflected in focus group discussions about the pressure to generate the 'right' outcomes for managers, commissioners and funding partners, rather than for service users.

All interview participants discussed a lack of physical safety, exposure to violence and difficulty finding relational support that met their needs. Complex needs among homeless people are often associated with complex trauma (Maguire, 2009). People with experiences of complex trauma require a sense of safety and stability before engaging in any trauma-focused work (Van der Kolk, 2003).

The role for support services

Evidence suggests that homeless people do better when they are housed (Keats, 2012). This finding, which may seem obvious, is the driver behind schemes such as Housing First (Tsemberis, 2011), where individuals are given precondition-free housing in conjunction with community-based clinical support (Nelson, Goering, & Tsemberis, 2013). These schemes can be expensive but have had success elsewhere in the world and have shown positive, preventative outcomes when compared to homeless individuals relying on temporary, inconsistent or unsafe accommodation (Blackburn et al., 2017).

The physical spaces and environments in which people live are linked to mental health outcomes (Townley, Millar, & Kloos, 2013). Psychological services could have a direct role in shaping how such environments are improved (Seagar, 2011). The concept of 'psychologically informed environments' (PIE) (Johnson & Haigh, 2012) requires thinking about how a house becomes a home, is drawn directly from psychodynamic theory. The development of a safe space, whether that is accommodation, day centre or clinic, provides a 'container' (Bion, 1962) or using attachment terminology, a 'secure base' (Bowlby, 2005) for both service users and support staff. The importance of this is recognised by third sector and statutory agencies and was included in national good practice guidance (Keats, 2012). Therapeutic approaches for individuals such as cognitive behavioural therapy and mentalisation-based therapy are beneficial for homeless populations, once 'basic needs' such as accommodation and health needs have been met (MacKnee & Mervyn, 2002).

Implications and Opportunities for Further Research

There are several ways this piece of research could be developed. Research has shown that women and minorities are more vulnerable to systemic prejudice and discrimination, which increases the risk of becoming homeless (Cochran, 2002). A piece of work examining the support seeking experiences of women, for example, could have important implications for the practical provision of support, given the limitations of accommodation for women reported by participants in this study.

Given that the psychological needs of homeless individuals are often overlooked (Brown, 2015), further research could emphasise the experiences and needs of individuals experiencing or who have experienced homelessness, as well as advocate for action to meet these needs. Late into the development of the project, the researcher became aware of participatory action research as a model for incorporating service user-led research into research departments (Kemmis, 2013). Additionally, utilising more creative approaches in future work, such as ethnography (Griffin, 2000) or incorporating visual media, like video (Wang, 2000) or photos (Macknee, 2002) could add a creative, immersive dimension to this type of research.

There are multiple opportunities for services and professionals working within homelessness services, and this piece of work has attempted to highlight that the challenges for professionals are not just identifying and naming sources of structural inequality but also contributing to a paradigm shift in how mental distress, material and relational deprivation are addressed by health and social care agencies. What

seems clear is that a multisectoral approach is required to address the multidimensional determinants that can lead to a person ending up homeless, including mental distress, drug or alcohol addiction or traumatic loss. An approach reflecting the micro, meso and macro factors that can create a pathway out of homelessness is required as well as increasing opportunities for choice and control for individuals seeking medical treatment, housing and psychological care.

Strengths and Limitations

Strengths of this study include the extent to which the researcher immersed himself in the community being researched as well as the data arising from the interviews and focus groups. Participants were of various ethnicities, genders and sexuality. Transcribing all interviews and focus groups meant that analysis felt natural and was supported by a substantial resource of initial notes, concepts and reflections. The rich data allows the reader to place it into the context of their knowledge (Smith et al., 2009). Through the process of analysis, the researcher hopes to have stayed close to the data, and close to the spirit and meaning of peoples experiences and their stories of seeking help. This research has attempted to give a voice to service users and professionals working in incredibly difficult conditions, coping with politically inflicted difficulties and systemic barriers to seeking a ‘good enough’ life.

Interview participants were recruited via posters, social media and word of mouth. Most were recruited via one site, the homeless hub, which means that the study may have attracted a subset of people who were keen to 'give back'. Thus, insights from individuals who are not likely to volunteer to participate in research might have been missed. Neither the length of time homeless nor the nature of homelessness was recorded.

Reflections on the project

The researcher was interested to find out what happens to homeless people who need support but can't access it. This interest came from his experiences as an Assistant Psychologist working in learning disability services who recognised that vulnerable people often have a hard time accessing the help they need as well as his sense of political frustration towards 'the system' for its contribution to people's difficulties.

The researcher expected to hear experiences from participants that were powerful, moving and potentially upsetting. He prepared himself for this to an extent by thinking about the impact of trauma during the lifespan, adverse childhood experiences and maladaptive coping mechanisms. However, the interviews required a great deal of emotional reflection and introspection and created a keen sense of

dealing with vicarious trauma. Using a reflective diary and attending supervision were useful during this process, as was spending time in the homeless hub, getting involved in some of the day to day activities of the homelessness organisations who were interested in the work.

The researcher felt a sense of apprehension, asking himself if his research was just a means for the same system to pay lip service to the struggles and pain endured by vulnerable people, with no real outcome or relief at the end? This was ameliorated in part by the participants disclosing how valuable it was to ‘tell their story' and feel they had contributed to something that might help.

Conclusions

The primary aim of this study was to examine the support seeking experiences of individuals who had experienced homelessness and alcohol or drug addiction, as well as to gather the experiences of professionals who work in services supporting homeless people. The study highlighted the realities of living without a home, without a ‘secure base’ and without a sense of physical or psychological safety. This included narratives about the ways people survived and got to a point of relative stability in their lives. The experiences contained within this study highlight how the idea of ‘hard to reach' was reciprocal in nature and replicated for service staff who were constrained by funding, cuts to statutory services and a lack of support, leading to feelings of powerlessness and frustration. The project included examples of changes to social policy and government spending since the advent of austerity in 2008 and how these policies have adversely impacted individuals’ physical and mental health, sense of self-efficacy and self-worth, and the ability of support services to provide 'good enough' care for vulnerable people. There is a clear need for further research and implications for the development and application of a role for clinical psychologists and other professions within this area.

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Appendices

Appendix A: Ethical Approval

D.Clin.Psychology Programme
Division of Clinical Psychology
Whelan Building, Quadrangle
Brownlow Hill
LIVERPOOL
L69 3GB

Tel: 0151 794 5530/5534/5877
Fax: 0151 794 5537
www.liv.ac.uk/dclinpsychol

7 December 2017

Ben Campbell
Clinical Psychology Trainee
Doctorate of Clinical Psychology Doctorate Programme
University of Liverpool
L69 3GB

RE: What is a "good life" for people who have been homeless and experienced substance addiction?
Trainee: Ben Campbell
Supervisors: Ste Weatherhead & Ross White

Dear Ben,

Thank you for your response to the reviewers' comments of your research proposal submitted to the D.Clin.Psychol. Research Review Committee (letter dated 09/11/17).

I can now confirm that your amended proposal (version number 8, dated 30/10/17) meets the requirements of the committee and has been approved by the Committee Chair.

Please take this Chairs Action decision as ***final*** approval from the committee.

You may now progress to the next stages of your research.

I wish you well with your research project.

Dr Catrin Eames
Vice-Chair D.Clin.Psychol. Research Review Committee.

Health and Life Sciences Research Ethics Committee (Psychology, Health and Society)

21 February 2018

Dear Dr Weatherhead

I am pleased to inform you that your application for research ethics approval has been approved. Application details and conditions of approval can be found below. Appendix A contains a list of documents approved by the Committee.

Application Details

Reference:	3107
Project Title:	What is a “good life” for people who have been homeless and experienced substance addiction?
Principal Investigator/Supervisor:	Dr Stephen Weatherhead
Co-Investigator(s):	Mr Benjamin Campbell, Dr Ross White
Lead Student Investigator:	-
Department:	School of Psychology (including DClinPOsych)
Approval Date:	21/02/2018
Approval Expiry Date:	Five years from the approval date listed above

The application was **APPROVED** subject to the following conditions:

Conditions of approval

- All serious adverse events must be reported via the Research Integrity and Ethics Team (ethics@liverpool.ac.uk) within 24 hours of their occurrence.
- If you wish to extend the duration of the study beyond the research ethics approval expiry date listed above, a new application should be submitted.
- If you wish to make an amendment to the research, please create and submit an amendment form using the research ethics system.
- If the named Principal Investigator or Supervisor leaves the employment of the University during the course of this approval, the approval will lapse. Therefore it will be necessary to create and submit an amendment form using the research ethics system.
- It is the responsibility of the Principal Investigator/Supervisor to inform all the investigators of the terms of the approval.

Kind regards,

Health and Life Sciences Research Ethics Committee (Psychology, Health and Society)

iphsrec@liverpool.ac.uk

0151 795 5420

Appendix - Approved Documents

(Relevant only to amendments involving changes to the study documentation)

Appendix B: Recruitment Poster for 1:1 Interviews

WHATS THIS ALL ABOUT?

We're interested in peoples stories about their experiences of being homeless and having a drug or alcohol addiction.

We know that services can be "hard to reach" for people who have complex needs, and we'd like to work toward changing that.

By listening to individuals experiences of what has worked for them, we hope to get a better idea of what works, and why.

WHO ARE WE?

We are researchers from the University of Liverpool who are interested in understanding and improving how services support people who need help.

HOW CAN YOU GET INVOLVED?

We'd love to hear from people who have experienced homelessness, and drug or alcohol addiction, and who would like to share their experiences. This can be anonymous and kept confidential. Get in touch to find out more.

If you are a professional, support worker or person with lived experience and would like to hear more about the research, get in touch using the info below.

CapableLiv@gmail.com

@CapableLiv

Appendix C: Focus Group Recruitment Poster

WHATS THIS ALL ABOUT?

We'd like to hear from people that work in homelessness services to talk about what works, and what doesn't.

We know that services can be "hard to reach" for people who have complex needs, and we'd like to work toward changing that.

If you are a professional, support worker or volunteer and would like to get involved, get in touch using the info below.

WHO ARE WE?

We are researchers from the University of Liverpool who are interested in understanding and improving how services support people who need help.

CapableLiv@gmail.com

@CapableLiv

Appendix D: Consent Form & Information Sheet

UNIVERSITY OF LIVERPOOL

Consent form and information sheet

It's useful for us to get some information about you so that we can get in touch with you when we need to, and to make sure you give your **consent** to take part in the research. **Consent means you say yes or agree to do something. If you change your mind at any time, that's ok!**

If there's anything you don't understand about filling in this consent form it's ok to ask someone for help.

Name

Born on

Address

Phone Number

Emergency Contact

UNIVERSITY OF LIVERPOOL

Consent form and information sheet

1:1 Interview Consent Form

Tick each box if you agree to take part ✔

Leave blank or put a cross if you do not consent, or if you aren't sure ✖

It's ok to ask someone for help to complete this form

1:1 Interview

Anonymous * information used for **Research**

**Anonymous information won't have you name on it, and no-one outside the research team will have access to your personal information*

Consent form and information sheet

Focus Group Consent Form

Tick each box if you agree to take part ✔

Leave blank or put a cross if you do not consent, or if you aren't sure ✖

It's ok to ask someone for help to complete this form

Focus Group Discussion

Anonymous * information used for **Research**

The focus group will be audio recorded and transcribed anonymously. Anonymous information won't have you name associated with it, and no-one outside the research team will have access to your personal information

UNIVERSITY OF LIVERPOOL

Consent form and information sheet

The information we use in this research will be anonymous and your name won't be used.

This information is **between you and the research team** and we will keep your personal information private.

The purpose of this piece of work is to listen to what your experiences have been, and to think about how services might need to change to support people better in the future. We hope to be able to show that there is a better way to support people who have experienced homelessness.

If you are taking part in the **one to one interviews**, we will have a chat and you will be able to **tell your story about seeking support** and how you've gotten help in the past. We will talk about what better support might look like.

If you are taking part in the **Focus Group**, we'll have a group discussion and you will be able to **talk about working in services or providing care**. We will talk about what better support might look like in the future.

The work we do together might be published and used to develop better services in the future.

Consent form and information sheet

By Taking part we agree that:

You will be treated well and with **respect**

All of your **information will be kept safe** in a locked cabinet and will be kept confidential.

We won't share your personal information with people outside of the research team.

If there's anything you don't understand or if you have any questions we will help you.

If you or someone you know is in danger **we will have to tell someone** who can help.

UNIVERSITY OF LIVERPOOL

Consent form and information sheet

Sign your name below if you understand what has been talked about in this form and if you **consent** to take part in the research project.

If you aren't sure about anything it's ok to ask for help.

Name

Date

Tick this box if you would like to be contacted about future research you might be interested in.

Appendix E: Interview Guide: 1:1 Interviews

INTERVIEW GUIDE – One to one interviews

(Please note: this is intended to be an interview guide to facilitate a conversation regarding the topics of interest. It is not a structured series of questions to be asked)

PRELIMINARIES:

Introductions: Explanation of research:

Confidentiality revisited: Opportunity to ask questions:

Demographics:

ID:_____ **Age:_____**

Participants will be asked to talk freely about their experiences which they consider to be important or personally relevant for them regarding their experiences of asking for help and getting support from others. The content of the interview will be dictated by the participant and the following questions will be used with prompts if they are not covered naturally in the course of conversation.

Prompts (where appropriate)

“How did you feel about that?”

“What was that like for you?”

“What was going through your mind?”

“How did you make sense of or understand... what was happening/that experience?

“Is there anything else you feel is important to say about that?

“How did you understand that at the time?”

Example opening:

So by this stage, you’ll have read the information leaflet and had a chance to ask any questions. You’ll have seen that part of this study is about understanding what its been like for you to be homeless, how you coped with that and how you sought out help and support.

- Can you tell me what it was like for you seeking help?
- What was going through your mind?
- How did you make sense of what was happening?
- Where were your thoughts taking you?
- How did you manage what was happening?

You'll remember from the original invitation for this study that I was interested in understanding the experiences of people who had looked for help and support to cope with what they were experiencing. We've already discussed some of that but I'm also interested in hearing specifically what that was like for you.

- Can you say a bit about how you asked for help?
- What was going through your mind?
- What did you do?
- Who did you rely on?
- What worked well for you?
- How did you experience support overall?
- What was missing?

Appendix F: Focus Group Interview Guides

INTERVIEW GUIDE – Focus Group

(Please note: this is intended to be an interview guide to facilitate a conversation regarding the topics of interest. It is not a structured series of questions to be asked)

PRELIMINARIES:

Introductions: Explanation of research:

Confidentiality revisited: Opportunity to ask questions:

Demographics:

Participants in the focus group will be asked to talk freely about their experiences as professionals which they consider to be important or personally relevant for them regarding role of support organisations in providing help to so called “hard to reach” groups. The content of the focus group will be dictated by the participants and the following questions will be used with prompts if they are not covered naturally in the course of conversation.

- What do you believe is the current role of organisations currently in providing support to “hard to reach” groups?
- What do you think about the themes of the research?

An introduction to the capabilities approach and Nussbaum’s 10 “capabilities” will be provided by the researcher at this point.

- What do you feel constitutes “good enough” support?
- Why do you think this?
- What is being achieved by service provision currently?
- Does this meet any criteria from the capabilities framework?
- What is missing from current service provision?
- What makes you think that?
- Does this meet any criteria from the capabilities framework?

Appendix G: Journal Submission Requirements

Journal Identified: International Journal of Qualitative Studies on Health and Wellbeing.

Link: https://www.tandfonline.com/toc/zqhw20/current

Aims and scope:

Aims: *International Journal of Qualitative Studies on Health and Well-being* (QHW) is an Open Access peer reviewed scientific journal that acknowledges the international and interdisciplinary nature of health-related issues.
QHW aims to provide a forum for the exchange of data, knowledge, theoretical framework and methods on health and well-being, aiming to further the development and understanding of qualitative research by using rigorous qualitative methodology of significance for issues related to human health and well-being.
The journal's focus is on empirical research, and we accept papers with both a national and/or international focus. We also welcome papers with a methodological focus and papers focusing on philosophical issues related to qualitative research in the health area.
Scope: *QHW* welcomes original research articles, review articles and short communications on qualitative research in relation to health and well-being as long as the articles meet high academic and ethical standards. We encourage qualitative researchers from a wide range of professional groups - and from anywhere in the world – to submit their work to *QHW*. All papers will be subjected to rigorous and fair peer review.
QHW publishes research articles within a variety of qualitative research approaches, qualitatively-driven mixed-method designs, methodological development, meta-analyses, and articles focusing on theoretical and philosophical issues related to qualitative research and health and well-being. For a research paper to be accepted for publication in *QHW* it must be written in a clear and concise manner, discuss findings in relation to existing literature, and use appropriate methodology for qualitative research.

Structure:

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

Word Limits
Please include a word count for your paper. There are no word limits for papers in this journal.

Format-Free Submission:

Authors may submit their paper in any scholarly format or layout. Manuscripts may be supplied as single or multiple files. These can be Word, rich text format (rtf), open document format (odt), or PDF files. Figures and tables can be placed within the text or submitted as separate documents. Figures should be of sufficient resolution to enable refereeing.

- There are no strict formatting requirements, but all manuscripts must contain the essential elements needed to evaluate a manuscript: abstract, author affiliation, figures, tables, funder information, and references. Further details may be requested upon acceptance.

- References can be in any style or format, so long as a consistent scholarly citation format is applied. Author name(s), journal or book title, article or chapter title, year of publication, volume and issue (where appropriate) and page numbers are essential. All bibliographic entries must contain a corresponding in-text citation. The addition of DOI (Digital Object Identifier) numbers is recommended but not essential.
- The journal reference style will be applied to the paper post-acceptance by Taylor & Francis.
- Spelling can be US or UK English so long as usage is consistent.

Appendix H: Example early 'emerging themes' used in Focus Groups

Theme	Participants	Descriptors
Physical effort to get from A to B	All	Difficulty obtaining transport: never use taxis, rarely use the bus, usually walk Knock on effects for appts, meetings etc: What if appt is across town in the rain and you haven't eaten? Or slept? Professionals don't seem to understand or factor in the above Walking everywhere: feeling tired, exhausted all the time.
Assault	Kate, Kayla, Simon, Jim	Participants talked about repeated physical assaults while sleeping rough – incidents were violent but also deeply shaming. Tolerating these assaults was accepted/expected - part of sleeping on the street- some felt that they wouldn't be welcome in hostels due to drug use/rules about curfews. Reference to feeling unsafe no matter where you slept – some hostels as dangerous Didn't feel able to approach police – worried about being "picked up" Police not a support.
Medical Care	All	Neglecting physical health par for the course. Worse if drug/alcohol use a problem – use substances to escape pain/discomfort, creates more pain, use more substances etc.

Seeking help re: substances	All	“Help” contingent on: ceasing use of substances, not always possible in timeframes suggested by organisations. Withdrawal seen as intolerable and not worth the eventual “support” on the other end. At best this works when organisations suggest a phased reduction of alcohol drugs in combination with support- being present with the person, no expectations to perform/behave a certain way during withdrawal.

Appendix I: Excerpts from Focus Group Thematic Analysis

Table X: Focus Group Thematic Analysis		
Theme	**Sub Theme**	**Example Supporting Quotes**
Professional 'Hoops'	Working within complex systems	"the services are not designed in a way that makes them accessible to people, particularly people that fall between or don't quite meet the criteria" "what we deem sometimes as health professionals that they don't have capacity, they go up on the ward and they deem them to have. So there's conflict between us as well. Oh actually we know this patient and a relative knows them, and they say, they're not their normal self." *"They won't share any data with us... [in the voluntary sector]… we need to get information to pass it on to the ward, but because we're bound by confidentiality and data protection… even with consent forms and everything."* *"It's so difficult... it's almost like you're working backwards. How many A&E admittances have we prevented? … there's no way to record that."* *"In whose eyes is it successful? For the provider or for the service user?"* *"it can be incredibly frustrating and it can be, again not so much in the service I've been in recently but I know at times having to, where you've got the sort of pressure you know, constantly having to justify why you're keeping a case open"* *"So when you refer somebody when you don't think they have capacity to make a decision, when they get referred and they get… 'noooo they've got capacity', even though you really feel like, no this person really isn't capable of making these decisions."*

		"in order to progress with people needing healthcare and stuff like that… we need to get information to pass to maybe ward or do everything, [service] is bound by confidentiality and data, and even though we try to get that information, they can't give us that information, even with the consent forms that we, sort of, have to put in" *"we work with this man quite a lot to try to get him into the office to try and get him to work with us, and with somebody who doesn't engage, it's so hard to get them to come and talk to you about it. So to not be able to get the information when you need it. Although I understand why, it can be quite frustrating."*
Invisible Labour		*"So, what are the personal qualities? Authenticity, integrity, commitment… I think it's just called the 'give a shit' factor."* *"I came into this job because I cared. I cared, and this is my humanity. But you've got to have the right people in the job, the people who say, 'let's sit down and talk about it'."* *"You do build up a sort of layer of armour, you know, you do tend to put things into boxes and put things away when you're not working with them, because you have to when you're working in that environment."*

Appendix J: Excerpts from stages of analysis of 1:1 interview data.

KATE emergent themes

Emergent themes	Transcript	Initial Comments
	Int: So, explained about the research that were doing so would you like to tell me a bit about yourself	
Services getting involved	yeah I was living in a house, a four bedroom house children with me find out my partner was carrying on behind my back, that all started the drink, and then it started where was drinking all day drinking before Sunday school and social services got involved and the kids got removed from the car once social Services are involved. then I lost the house as well. I became homeless. I was staying in	**Alcohol as coping**. **Breach of trust**. *Removed. Lost. Taken* Loss of house and children. Homeless.
Help Finished/Staying put	Geneva house. then my son was taken into care, but I really wanted to stay on my own house, so I went back to the house and stayed in there is no Windows just metal sheets. I didn't have any Electricity or gas or that. House was freezing. Help from Geneva house finished because you only stay there for so long, for a certain	
Help for a period	amount of days, for a certain period of time. then I was living on the streets. used to travel, used to walk from time to wave of hope, up Parliament Street and back. I wasn't sleeping so I got ill, I was having seizures. Still drinking. gradually I got off the yeah, I've been off the I've been clean for a year now. get to see my children	Squatting. **Time limited support** Becoming ill – lack of self-care. *Still* Clean for a year
Keeping things the way I want	eye contact. it is hard because I can speak to them on the phone or anything. and waves of Hope help me get my flat. it's dead quiet it's dead nice. be able to keep it the way I want and stay clean. it was hard but really hard staying on the streets really really hard. got people peeing on you got people making fun of you shout names at you. it was really hard I got attacked in town I was going to boot to the head. I had to go to the Royal. it was all caught on CCTV all caught on camera. it	**Conditional contact**. Hard on streets. *Hard. Waves.* **Ownership and control of own space** Humiliation on streets
Alcohol as coping – attracting connection	was at the car park there are three of them. they kept me in for a bit and I felt a bit better then because I wasn't drinking. Then I come out and then I started drinking again. the drink takes away the problems but then there they were there the next day. I was drinking all the time and a bit of money that had I was buying drink. and I was buying drink for everyone I knew, for my friends.	Assault **Conditional support** **Cycle of harm – trapped.** **Alcohol as a means of attracting connection**
Embarrassed by Drinking	coming here it's been like a second family If you know what I mean there's quite a lot of us have all had similar experiences. and been in similar situations. and they can relate to that. and you know one of very first came I was a bit embarrassed because I was still drinking. and obviously other people wearing other people with	

1

KATE emergent themes

Help got me through	recovering alcoholics it was hard at first, but New Beginnings and waves of Hope have got me through an awful lot without them I would still probably be on the streets and without nothing. They're really really good **Int:** it sounds like they've been really supportive yeah, they have **Int:** so, whenever this for offers happened how did you feel you were that you said your relationship broke down you started drinking, I really feeling there was going on for you the time?	Connection. Quality. Peer support - - universality of experience. *Similar. relate.* Shame as a barrier to connection. *Embarrassed.* *Really as emphasis.* Significant of support. Positive experience of help seeking. Important of others
Duality of seeking connection	it was a lot of things I was just left with it all, with the kids. it was always me left with things it was always me that had to be the mother and the father. and because I had love for them and I heard of someone else that he was carrying on and it really took me back, and I started drinking. I used to drink of a night. but then I started drinking in the morning as well. So, it just became easy for just to be all day. Just be drinking all day. **Int:** when this all First started were you able to get help anywhere? Was there anywhere to support you?	Left with it all. Abandoned. Alcohol as coping Easy – escape.
Hurdles to connect	I went to sanctuary… Sharon at sanctuary she was lovely. I'd be tested I got a machine had to do that for them to see if you're over the limit had to do that quite a few times and it was low, so i wasn't drinking that excessively do you know what I mean but even when I was at the hostel I was drinking I was sneaking drinks in stuff like that. **Int:** Whenever you first started drinking at home the kids were taken into care was there any avenues of support available to you? could you tell it to your GP? or was there anyone to talk to?	Seeking support Relying on alcohol to cope.

Appendix K: Excerpts from stages of analysis of individual 1:1 interview data.

Theme & Analysis			INT 1: Kate
Superordinate themes	**Subordinate themes**	**Emerging themes**	**Supporting text**
Loss of integrity of the self	**Wavering hope**	***Hard world***	"it's horrible being homeless. the world is a very hard place."
		No sleep	"That was the cause of the seizures because I wasn't sleeping, and I was just drinking when I was losing weight terrible and being on the streets. the worst thing was not sleeping at the on the bus and I'd fall asleep. I fall asleep on the bus by accident. the bus driver came up and gave me a shove and said this is the last stop. and I was further than where I was supposed to be. "
		Horrible experiences	"it was hard it was a horrible experience being in [hospital]. "
		Embarrassed by drinking	"you know one of very first came I was a bit embarrassed because I was still drinking. and obviously other people were recovering alcoholics… it was hard at first"
	Attempts to Manage	***Drinking blocks out shame***	"when I look at stuff, I think you stupid cow. but then you don't think of that when you are drinking. your mind just blocks out things."
		End my life	"because I wanted to end my life. I just had all these thoughts in my head. I wanted to go to the prom and throw myself into the sea."
		Suicide	
		Couldn't keep alcohol up	"after being in town and having seizures and stuff like that. I couldn't keep doing it anymore. "
		Buying friends	"I was buying drink for everyone I knew, for my friends."
		Drinking to block out	"just want to drink my problems away and deal with it the day after. and that's why I was drinking I was trying to block out everything."
	Living with exclusion	***Going with the flow***	"I would just go with the flow I would just go over where was open I would go to [service]; I would go into town. trying to find out if there was any way for me to stay. anywhere for me to go."

		Blacked out	"it was quite scary, it was in a hospital transport with like blacked out windows, it took me up there and I didn't know where I was. I didn't know at all. "
		Thrown out	" [on hospital ward] it was awful you were surrounded by people all different people. people who didn't know me or why I was there. they threw me out after a day. because I got into an argument with someone. they wouldn't let my key worker pick up my medication "
		Threw me out	"didn't really get any support, I didn't speak with anybody. then they threw me out."
		On my own	"Didn't know where i was, didn't have any form of contact with anyone. I was on my own "
	Disempowered Help Seeker	***My own little world***	"it's like you're being passed from pillar to post. I was in like my own little world. I was saying things, but it didn't mean anything to anybody it was just stuff that was in my head. "
		Finish my life – suicide	"felt really bad I wanted to finish my life but then I thought how would the kids feel. how would the little ones feel "
		Services getting involved	"social services got involved and the kids got removed from my care once social Services were involved…. then I lost the house as well. I became homeless "
		Help finished	"Help from [agency] finished because you only stay there for so long, for a certain amount of days, for a certain period of time. "
		Staying put	"then my son was taken into care, but I really wanted to stay on my own house, so I went back to the house and stayed in there is no Windows just metal sheets. I didn't have any Electricity or gas or that. House was freezing"
		Confusing process	"[service] that paid for me to stay, had to stay above a pub which wasn't the best thing. they got me a room like a hotel. I stayed there until they finally got me a place. the whole process was really confusing for me. going onto property sites. "
		Took me away	"I came into the [hospital] and they sectioned me under a section 2. and they took me to [different city]. the Hospital in [different city]."

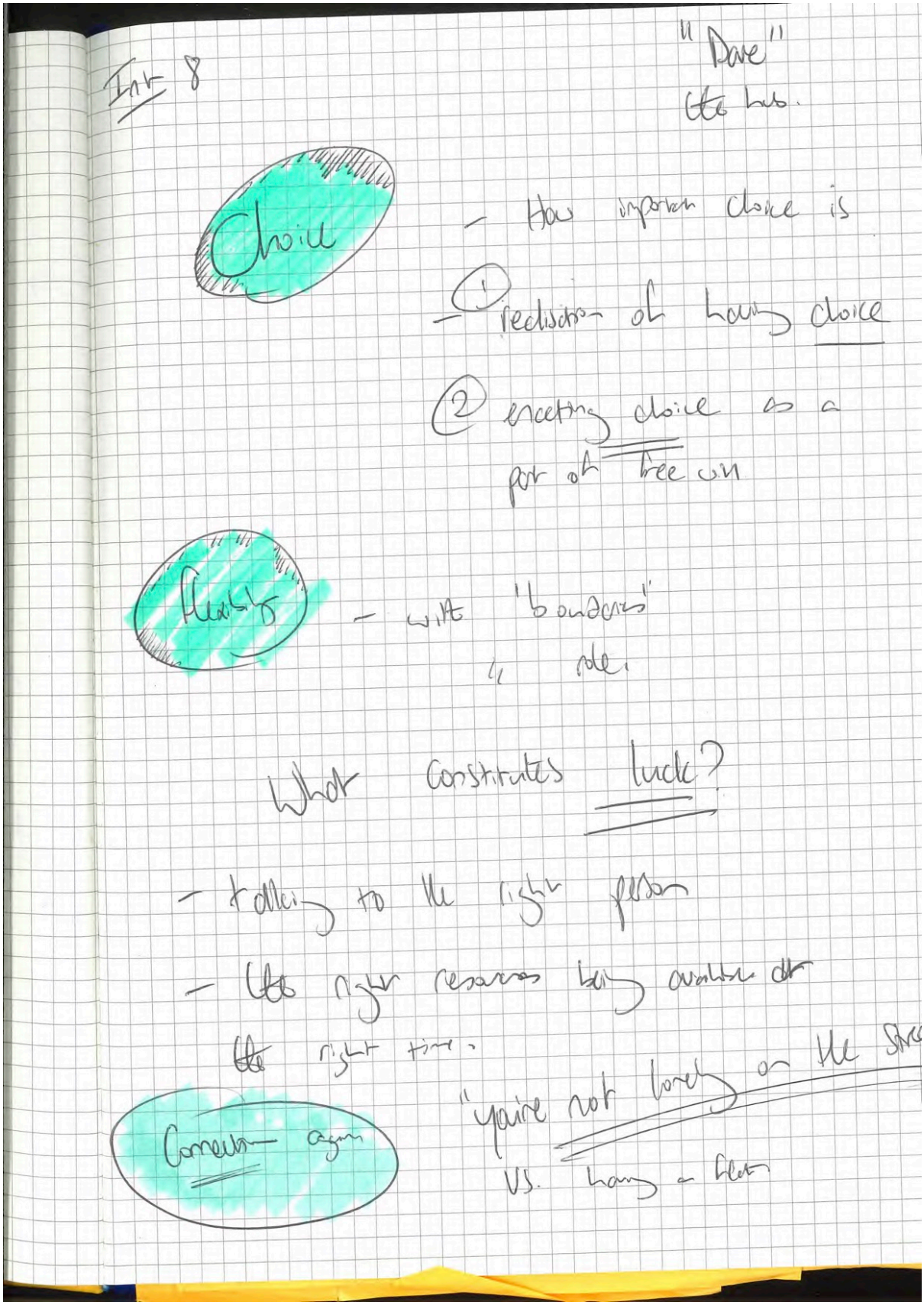
Appendix L: Excerpts from cross case analysis of 1:1 interview data.

Table X 2 Master table of Superordinate themes			
Master Theme	**Sub theme**	**Superordinate Themes**	**Example Supporting Quotes**
Sense of Self Smashed by the Streets	Loss of integrity of the self	Loss of integrity of the self I1, I6, I8, I2	*" [on hospital ward] it was awful you were surrounded by people all different people. people who didn't know me or why I was there. they threw me out after a day. because I got into an argument with someone. they wouldn't let my key worker pick up my medication "* Kate *"it was embarrassing… that was 'cos the seizures... because I wasn't sleeping… I was losing weight terrible… the worst thing was not sleeping, and on the bus, I'd fall asleep. I'd fall asleep on the bus by accident. The bus driver came and give me a shove and said this was the last stop. I was further than I needed to be"* – Kate *"I don't think [hostels] look at the vulnerabilities of the person... at [hostel] if you're not back by a certain time they won't let you back in... which is ridiculous… you've got lots of women prostituting themselves… escorting... there's men there… smoking spliffs, and the staff don't say anything. And I just think, what? When did this happen? it's a roof over [your] head but it's not good for people… not for vulnerable people." – Kelly* *"I knew that I had no self-worth and no self-esteem. People used to throw drinks on me piss on me… people used to spit at me… when I was on the doorways and stuff... and that just adds too how shit you feel anyway. It just makes you fucked... your living conditions are reduced to the animal level" – Simon* *"… sometimes the only way to get a good kip is to get smashed. I read somewhere that if you don't sleep it can kill you and that really scared me because I never sleep well unless I'm smashed. I've read about the fact you can get psychosis if you don't sleep…" Matt*
	Surviving Structural Violence	Structural violence against the self I1, I2, 14, 15, 17, 18	"I was kicked out" - Simon "I was thrown out" - Kate "[I was] kicked out" - Kayla "I was chucked out" - Jim

			"I was kicked out" – Dave "[we were] ... kicked out" – Kelly *"… they were supposed to taking care of us but instead they knocked the fuck out of us… it's not a nice environment... just constantly fighting. People were scalded with sugar and water, there are worse things out there... slashings there..." - Simon* *"you got people peeing on you, got people making fun of you… I got attacked in town. Got a boot to the head"* – Kate *"I got stopped by the police for no fucking reason. Walking down my friend's road. They asked me if I'd ever been known to the police… then they wanted to know what's in my pockets… I don't want to say it's like being raped, but… it's physical intimidation… then they will stitch you up"* – Matt
	Protecting the vulnerable self	Protecting the vulnerable self	*"it felt odd. like I was the odd one out. I didn't know where I fit it in. I didn't fit in with people in prison I didn't fit in with people outside I didn't really fit in with people off the streets didn't really fit in with anyone. but now I've got my own flat I don't need to fit it with anyone I can just be myself and try and make myself better and that's what I'm doing really at the moment*." – Liam *"I was getting sick of it… it was scary. The staff were fantastic but it was the people that were sleeping there as well… it was scary I think for a woman, being in a circumstances like that. I've never felt so vulnerable in my life... I've been in prison and I was ok. I was in a hostel I was alright... but being there it was scary… inside I was dying. It was killing me. I'd curl up into a ball and cry. I'd say please God get me out of here. I needed help but I didn't know what help I could get. " - Kayla* *"I think probably the hatred that I had for services and stuff like that I probably brought that in on myself.. so I turned it against myself and I hated myself. and then I used to go through phases... I need to think these are the cards you've been dealt and this is the life you're going to live. and maybe this is just the Way It Is. "* Simon

	Connection with others	Connection with others I4 Preservation through connection I2 Becoming a connected being I7 Challenging neglect through connecting I6	*"I would like to actually be up look after her the way she's looked after me. get a career."* Liam *"but what I really want to do is just to be with someone. like his house is a shithole but it's just having the human contact."* Matt *"People have it all in jail… they have community they have friends... they love the banter, they love all the buying and selling... it becomes their family and their way of life... so, when they come out... they're grieving for that. They're at a loss." - Simon* *"the connection that I have with people in the room it's amazing. I know that I belong there. I feel like I'm at the start of an amazing journey. I feel a lot happier in myself. I listen to people on the meetings and they listen to them share. "* - Kayla "*a good life for me is obviously being free from drugs. a good life for me is honestly just having a clean bed and clean clothes a bit of peace a bit of sanity in my mind engage in life the ability to feel feelings and connect with people…."* Simon *"I never went to one place for tea or anything like other people did. I never went anywhere to sleep. I would just go back and forward from different places. walk into town, out of town. I'd walk up to heaven, at Castle Street, talk to all the people going out. talk to the bouncers all night until the morning. I just keep walking. it was tiring. "* - Kate *"the most important thing is choices.. having a choice... having a choice of what you do. having connection with other people. "* – Dave

Appendix M: Excerpts from Reflective Diary



Int number 2

ID: "Ner"
location: Hub.

A1c → Blocks our problems

Stops smell, exercise.

Detox, Hostels = ↓ dc, ↑ problems.

Being intoxicated is preferable to being sober with ↑ problems + no support.

"first time i came out of detox, I couldn't cope

Dejected, rejected, alone follow ends with sex.

↳ so why bother?

What I would? sent to Family

talking, cards, tea, food

'hub' - you can pop in

→ no expectations.

Funding / 3rd Sector Support services

- Rigid guidelines for commissioning
- We can take on 'x' but not 'y'

reject help

market exclusion

any other of help is contingent on dropping ①

rejecting

lack of Communication between orgs.

- no data sharing
- lack of governance

no clear consensus of what people need

can't offer needs based support

rejected

needs not met

potential rejection of

① turn to other means of support

Appendix N: Search Terms for Systematic Review

Table 4: Systematic Search. Searched up to 04/03/2019					
Database	**Controlled Vocabulary**				
	Capabilities	**Mental Health**	**Mental Health Services**	**Limiters**	
Psych INFO	S1 “Capabil* approach” OR “Human Development” OR agency OR “functionings” OR “FLOURISHING” OR “LANGUISHING” OR “subjective well*”	S2 DE "Mental Health" OR DE "Mental Status" OR DE "Chronic Mental Illness" OR DE "Chronic Psychosis" OR DE "Mental Disorders" OR DE "Borderline States" OR DE "Thought Disturbances" OR DE "Affective Disorders" OR DE "Anxiety Disorders" OR DE "Autism Spectrum	S3 DE "Mental Health Programs" OR DE "Crisis Intervention Services" OR DE "Deinstitutionalization" OR DE "Home Visiting Programs" OR DE "Hot Line Services" OR DE "Suicide Prevention Centers" or DE "Mental Health Services" OR DE "Community Mental Health Services" OR DE "Community Mental	Qualitative Research English Language Academic Journals	S1 AND S2 OR S3

		Disorders" OR DE "Bipolar Disorder" OR DE "Chronic Mental Illness" OR DE "Dissociative Disorders" OR DE "Eating Disorders" OR DE "Gender Dysphoria" OR DE "Mental Disorders due to General Medical Conditions" OR DE "Neurocognitive Disorders" OR DE "Neurodevelopmental Disorders" OR DE "Neurosis" OR DE "Paraphilias" OR DE "Personality Disorders" OR DE "Psychosis"	Health Services" OR DE "Community Counseling"		

		OR DE "Sleep Wake Disorders" OR DE "Somatoform Disorders" OR DE "Stress and Trauma Related Disorders" OR DE "Substance Related and Addictive Disorders"			
SCOPUS	(TITLE-ABS-KEY (("capabilities approach") OR ("Human development approach") OR "agency" OR "FUNCTIONINGS" OR "FLOURISHING" OR "LANGUISHING" OR ("SUBJECTIVE WELL*"))	AND DOCTYPE (ar)) AND (mental AND health) OR "Mental Health" OR "Mental Status" OR "Chronic Mental Illness" OR "Chronic Psychosis" OR "Mental Disorders" OR "Borderline States" OR "Thought Disturbances" OR "Affective Disorders" OR "Anxiety Disorders" OR "Autism Spectrum Disorders" OR "Bipolar Disorder" OR "Chronic Mental Illness" OR "Dissociative		Qualitative research English Language	

		Disorders" OR "Eating Disorders" OR "Gender Dysphoria" OR "Mental Disorders due to General Medical Conditions" OR "Neurocognitive Disorders" OR "Neurodevelopmental Disorders" OR "Neurosis" OR "Paraphilias" OR "Personality Disorders" OR "Psychosis" OR "Sleep Wake Disorders" OR "Somatoform Disorders" OR "Stress and Trauma Related Disorders" OR "Substance Related and Addictive Disorders" OR "Mental Health Programs" OR "Crisis Intervention Services" OR "Deinstitutionalization" OR "Home Visiting Programs" OR "Hot Line Services" OR "Suicide Prevention Centers" OR "Mental Health Services" OR "Community Mental Health Services" OR "Community Mental Health Services" OR "Community		

		Counseling" AND (LIMIT- TO (EXACTKEYWORD , "Qualitative") OR LI MIT-TO (EXACTKEYWORD , "Qualitative Analysis") OR LIMIT- TO (EXACTKEYWORD , "Qualitative And Quantitative Research Methods") OR LIMIT- TO (EXACTKEYWORD , "Qualitative Approach") OR LIMIT- TO (EXACTKEYWORD , "Qualitative Approaches")) AND (EXCLUDE (EXACTKEY WORD , "Human Experiment") OR EXCLUDE (EXACTKEYWO RD , "Randomized Controlled Trial") OR EXCLUDE (EXACTKEYWORD , "S tatistics And Numerical Data") OR EXCLUDE (EXACTKEYWORD , " Neuropsychological Tests")) AND (LIMIT- TO (LANGUAGE , "English"))			
Web of Scienc e	(ALL= ("CAPABILIT* APPROACH" OR "HUMAN	(ALL= ("Mental Health" OR "Mental Status"	(ALL= ("Mental Health Programs" OR "Crisis	(ALL= ("Qualitative Methods" OR "Focus	

	DEVELOPMENT APPROACH" OR FUNCTIONINGS OR AGENCY OR FLOURISHING OR LANGUISHING OR "SUBJECTIVE WELLBEING"))	OR "Chronic Mental Illness" OR "Chronic Psychosis" OR "Mental Disorders" OR "Borderline States" OR "Thought Disturbances" OR "Affective Disorders" OR "Anxiety Disorders" OR "Autism Spectrum Disorders" OR "Bipolar Disorder" OR "Chronic Mental Illness" OR "Dissociative Disorders" OR "Eating Disorders" OR "Gender Dysphoria" OR "Mental Disorders due to General Medical Conditions" OR	Intervention Services" OR "Deinstitutionalization" OR "Home Visiting Programs" OR "Hot Line Services" OR "Suicide Prevention Centers" OR "Mental Health Services" OR "Community Mental Health Services" OR "Community Mental Health Services" OR "Community Counseling"))	Group" OR "Grounded Theory" OR "Interpretative Phenomenological Analysis" OR "Narrative Analysis" OR "Semi-Structured Interview" OR "Thematic Analysis")) English Language Academic Journals	

		"Neurocognitive Disorders" OR "Neurodevelopmental Disorders" OR "Neurosis" OR "Paraphilias" OR "Personality Disorders" OR "Psychosis" OR "Sleep Wake Disorders" OR "Somatoform Disorders" OR "Stress and Trauma Related Disorders" OR "Substance Related and Addictive Disorders"))			
CINAHL	S1 (“Capabil* approach") OR (“Human Development”) OR "agency" OR “Functionings” OR	S2 (MH "Mental Status") OR (MH "Diagnosis,	S3 (MH "Mental Health Services+") OR (MH "Community Mental	S4 (MH "Qualitative Studies+")	S1 AND

	“FLOURISHING” OR “LANGUISHING” OR (“subjective well*”)	Psychosocial+") OR (MH "Mental Disorders+") OR (MH "Mental Health")	Health Services+") OR (MH "Substance Abuse and Mental Health Services Administration")	English Language Articles	S2 OR S3 AND S4
ProQuest	(“Capabil* approach”) OR (“Human Development”) OR "agency" OR “Functionings” OR “FLOURISHING” OR “LANGUISHING” OR (“subjective well*”)	MAINSUBJECT.EXACT("Mental disorders") OR (MAINSUBJECT.EXACT("Mental health care") OR MAINSUBJECT.EXACT("Mental health"))		MAINSUBJECT.EXACT("Qualitative research") English Language Articles, Journals	

Appendix O : Papers Excluded Following Full Text Review

Table 5: Papers excluded following full text review

Author	Title	Reason for Exclusion
Tania Burchardt	**Capabilities and disability: the capabilities framework and the social model of disability**	**Did not include any mention of application CA within a MH context**
Gulia Greco	**What is a good life? Selecting capabilities to assess women's quality of life in rural Malawi**	**Did not include a mental health context**
M. Pippin Whitaker & Tamara Estes Savage	**Social-ecological Influences on Teen Dating Violence: A Youth Rights and Capabilities Approach to Exploring Context**	**Did not include a mental health context.**
Mia Kibela, Meredith Vanstone	**Reconciling ethical and economic conceptions of value in health policy using the capabilities approach: A qualitative investigation of Non-Invasive Prenatal Testing**	**Did not include a mental health Context**
Ben Heaven	**Mobilizing Resources for Well-being: Implications for Developing Interventions in the Retirement Transition**	**Applied to wellbeing generally, no focus on MH.**
Sarah M. Harta, Janet S. Gaffneyb and Mary F. Hillc	**Critical reflections on emancipatory partnerships in transition research: discerning perspectives of New Zealand Students on the autism spectrum**	**Outside of a MH context.**
Amber M. Angell,	**Latino Families' Experiences with Autism Services: Disparities, Capabilities, and Occupational Justice**	**Outside of a MH context.**

Kim Hopper	**Rethinking social recovery in schizophrenia: what a capabilities approach might offer.**	**Commentary**
Thurman, W	**Social Context and Value based care: a capabilities approach for addressing health disparities**	**Commentary**
Venkatapuram, S	**Capability to be Healthy – Implications for prevention**	**Commentary**
Ware, N	**A theory of social integration as quality of life**	**No direct application of CA**
Stenlund, M	**Promoting Freedom of thought of mental health service users: Nussbaum's Capabilities approach meets values-based practice.**	**Commentary**
White, R	**The capabilities approach: fostering contexts for enhancing mental health across the globe.**	**Debate/Commentary**
Lewis, L	**The capabilities approach, adult community learning and mental health**	**Policy discussion**

Appendix P: CASP Quality Appraisal Table

Appendix L: Full Text Quality Appraisal							
Paper Title	**Author**	**Section A- Are the results valid?**					
		Clear statement of Aims?	**Appropriate Methodology**	**Appropriate Research Design**	**Appropriate recruitment**	**Data Collection**	**Researcher/ Participant Relationship**
The Capabilities Questionnaire for the community mental health context (CQ-MH)	Sachetto, 2015	Y	Unsure	Unsure	Y	Y	Y
Capabilities Approach: Contextualising participants' perspectives on systems barriers to recovery	Petros et al, 2016	Y	Y	Unsure	Unsure	Y	Y
Creating Capabilities through maternal mental health interventions: a case study at Hanover Park, cape town	Meintjes et al, 2015	Y	unsure	Unsure	Unsure	Y	Unsure
The impact of antenatal mental distress on functioning and capabilities	Mall et al, 2013	Y	Unsure	Unsure	Unsure	Unsure	unsure
Reconceptualising involuntary	Light, et al, 2016	Y	Y	Y	Y	Y	Y

outpatient psychiatric treatment: from capacity to capability							
Using a capabilities approach to understand poverty and social exclusion of psychiatric survivors	Benbow et al, 2014	Y	Y	Y	Y	Y	Y
Why do people with mental distress have poor social outcomes? Four lessions from the capabilities approach	Brunner, 2017	Y	y	y	y	y	y
Using the capabilities approach to understand inequality in primary mental healthcare services for people with severe mental illness	Lavie-Ajayi, 2018	Y	y	y	y	y	Unsure
Partners in Recovery: Social Support and Accountability in	Lewis, S. 2012	Y	Y	Y	Y	Unsure	Unsure

a Consumer-Run Mental Health Centre.							
Connectedness and Citizenship: Redefining Social Integration	Ware et. al. 2007	Y	Unsure	Unsure	Unsure	Unsure	Unsure

Full Text Quality Appraisal							
Paper Title	**Author**	**Section B – What were the results?**					
		Ethical Considerations	**Rigorous Analysis**	**Clear statement of findings**			
The Capabilities Questionnaire for the community mental health context (CQ-MH)	Sachetto, 2015	Some acknowledgment of adaptations to suit the population.	Yes	Yes			
Capabilities Approach: Contextualising participants' perspectives on systems barriers to recovery	Petros et al, 2016	Not explicitly stated	Yes	Yes			
Creating Capabilities through maternal mental health	Meintjes et al, 2015	Not explicitly stated	Yes	Yes			

interventions: a case study at Hanover Park, cape town							
The impact of antenatal mental distress on functioning and capabilities	Mall et al, 2013	Some considered	Unsure	Yes			
Reconceptualising involuntary outpatient psychiatric treatment: from capacity to capability	Light, et al, 2016	Some considered	Yes	No			
Using a capabilities approach to understand poverty and social exclusion of psychiatric survivors	Benbow et al, 2014	Yes - acknowledgment of the mental health of participants and need for consent	Yes	Yes			
Why do people with mental distress have poor social outcomes? Four lessions from the capabilities approach	Brunner, 2017	Unsure, some consideration - role of bias considered.	yes	yes			
Using the capabilities approach to understand	Lavie-Ajayi, 2018	Yes - informed consent obtained. No discussion of other ethical considerations	Unsure	yes			

inequality in primary mental healthcare services for people with severe mental illness							
Partners in Recovery: Social Support and Accountability in a Consumer-Run Mental Health Centre.	Lewis, S. 2012	Not explicitly stated	Unsure	Yes			
Connectedness and Citizenship: Redefining Social Integration	Ware et. al. 2007	Informed consent obtained from participants	Unsure	Yes			

Full Text Quality Appraisal		
		Section C – Will the results help locally?
Paper Title	**Author**	**How valuable is the research?**
The Capabilities Questionnaire for the community mental health context (CQ-MH)	Sachetto, 2015	clear conclusions and implications for practice
Capabilities Approach: Contextualising participants' perspectives on systems barriers to recovery	Petros et al, 2016	Clear conclusions and implications for practice
Creating Capabilities through maternal mental health interventions: a case study at Hanover Park, cape town	Meintjes et al, 2015	Systemic recommendations, no development for future research, no suggestions for future research.
The impact of antenatal mental distress on functioning and capabilities	Mall et al, 2013	Some usefulness re: CA and mental health – some links to potential application noted.
Reconceptualising involuntary outpatient psychiatric treatment: from capacity to capability	Light, et al, 2016	No recommendations for further work, some clear conclusions re: conceptualisation of MH systems and theoretical reference to the CA.

Using a capabilities approach to understand poverty and social exclusion of psychiatric survivors	Benbow et al, 2014	Some recommendations for future work at the service level. Links to practice stated.
Why do people with mental distress have poor social outcomes? Four lessions from the capabilities approach	Brunner, 2017	Clear rationale for future use of CA. Clear implications for future operationalising of the model. No recommendations for further work.
Using the capabilities approach to understand inequality in primary mental healthcare services for people with severe mental illness	Lavie-Ajayi, 2018	Clear findings noted. Recommendations for future practice. Issues to be addressed named. No recommendations for future work.
Partners in Recovery: Social Support and Accountability in a Consumer-Run Mental Health Centre.	Lewis, S. 2012	Findings reported with some clear limitations of the work- implications for the role of 'choice' when it comes to decision making re: treatment planning and coworking options between professionals and clients.
Connectedness and Citizenship:	Ware et. al. 2007	Some usefulness of findings reported; tentative exploration of the application of findings. Some links to service provision stated.

Redefining Social Integration		